Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with

OMB Nos. 1210-0110 1210-0089

2017

_	Administration	the instructions to the Form 5500.			ı 		
Pensio	on Benefit Guaranty Corporation				This	Form is Open to Pเ Inspection	ublic
Part I	Annual Report lo	dentification Information					
For caler	ndar plan year 2017 or fisc	cal plan year beginning 01/01/2017		and ending 12/31/20	017		
A This r	return/report is for:	a multiemployer plan	participating	nployer plan (Filers checking t employer information in accor			ns.)
		X a single-employer plan	a DFE (speci	fy)			
B This r	return/report is:	the first return/report	the final retur	·			
		an amended return/report	a short plan y	ear return/report (less than 1	2 months)	<u></u>	
C If the	plan is a collectively-barg	ained plan, check here				> []	
D Chec	k box if filing under:	X Form 5558	automatic exte	ension	the	e DFVC program	
		special extension (enter description	on)				
Part II	Basic Plan Infor	mation—enter all requested informa	ition				
	ne of plan L A. RAMIREZ & CO. HE	ALTH AND WELFARE BENEFITS PL	AN		1b	Three-digit plan number (PN) ▶	501
					1c	1c Effective date of plan 01/01/2016	
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)						2b Employer Identification Number (EIN) 13-2695511	
SAMUEL	A. RAMIREZ & CO., INC				2c Plan Sponsor's telephonumber 212-378-7198		
61 BROA SUITE 29 NEW YO		61 BROADWAY SUITE 2924 NEW YORK, NY 10006			2d	Business code (see instructions) 523120	9
Caution	: A penalty for the late o	r incomplete filing of this return/rep	ort will be assessed	l unless reasonable cause i	s establis	shed.	
Under pe	Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.						
SIGN HERE Filed with authorized/valid electronic signature. 10/03/2018 CHRISTINE LONG							
	Signature of plan administrator Date			Enter name of individual signing as plan administrator			
SIGN HERE							
HERE	Signature of employer	plan sponsor	Date	Enter name of individual s	igning as	employer or plan sp	onsor

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

SIGN HERE

Signature of DFE

Form 5500 (2017) v. 170203

Enter name of individual signing as DFE

	a		
3a	Form 5500 (2017) Page 2 Plan administrator's name and address X Same as Plan Sponsor	3b Administrato	r's EIN
		3c Administrato number	r's telephone
4 a	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: Sponsor's name	4b EIN 4d PN	
С	Plan Name		
5	Total number of participants at the beginning of the plan year	5	133
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		
a(1) Total number of active participants at the beginning of the plan year	6a(1)	133
a(2) Total number of active participants at the end of the plan year	6a(2)	141
b	Retired or separated participants receiving benefits	6b	
С	Other retired or separated participants entitled to future benefits	6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c.	6d	141
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e	
f	Total. Add lines 6d and 6e .	6f	141
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)		
	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Could be plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Could be plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Could be plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Could be plan provided benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Could be plan provided benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Could be plan provided by the plan provided benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Could be plan provided by the plan provide		
	(3) Trust (3) Trust (4) X General assets of the sponsor (4) X General assets of the	n(3) insurance contrac ne sponsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the n	umber attached. (See	e instructions)
a	Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan (3) A (Insurance I	formation – Small Pla	n)

(4)

(5)

(6)

C (Service Provider Information)D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

actuary

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

(3)

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)				
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)					
11b Is the	plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)				
Recei	the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the pt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid pt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)				
Rece	ipt Confirmation Code				

Form 5500 (2017)

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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

		pursuant to El	RISA section 103(a)(2).				Inspection	
For calendar plan year 20°	17 or fiscal plan	year beginning 01/01/2017		and en	ding 12/3	1/2017	•	
A Name of plan SAMUEL A. RAMIREZ &	AND WELFARE BENEFITS PLAN	N		e-digit number (PN	ı) >	501		
C Plan sponsor's name as shown on line 2a of Form 5500 SAMUEL A. RAMIREZ & CO., INC. D Employer Identification Number (13-2695511					ation Number (EIN)		
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance car VISION SERVICE PLAN	rrier							
(L) FIN	(c) NAIC	(d) Contract or	(e) Approximate nui			Policy or co	contract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To	
22-2777159	47029	30018804	96		01/01/2017	7	12/31/2017	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and tota	Il commissions paid. Lis	st in line 3	the agents, I	orokers, and ot	her persons in	
(a) Total a	amount of comr	missions paid		(b) To	tal amount o	of fees paid		
		834					0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all p	ersons).				
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commiss	ions or fees	were paid		
KINLOCH CONSULTING (GROUP, INC.	STE 260	VILLE PARK RD 0 LE, NY 11747-3156					
(b) Amount of sales an	nd base	Fees	s and other commission	s paid				
commissions pai		(c) Amount	(0	(d) Purpose		(e) Organization code		
	680						3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commiss	ions or fees	were paid		
MBL BENEFITS CONSULT		323 W 3 FL 11	99TH ST ORK, NY 10018					
(b) Amount of soles are	nd booo	Fees	s and other commission	s paid				
(b) Amount of sales an commissions pai		(c) Amount	•		(d) Purpose		(e) Organization code	
·	154		,	·			3	
For Paperwork Reduction	n Act Notice, s	see the Instructions for Form 5	500.			Sched	lule A (Form 5500) 2017	

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio suoio di promini rutos				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		İ	7d	
		Deductions:	Γ			
	•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

F	Part	III	Welfare Benefit Contract Information for than one contract covers the same the information may be combined for report employees, the entire group of such individual.	group of employees of the ing purposes if such cont	racts are exp	perience-rated as a uni	t. Where co	ntracts cover inc	
8	Ben	efit a	nd contract type (check all applicable boxes)			<u> </u>		•	
	а	ТНе	ealth (other than dental or vision)	b Dental	c	Vision		d Life insura	ince
	e [=	emporary disability (accident and sickness)	f Long-term disabilit	<u> </u>	=	nlovmont	h Prescription	
		=		=		= ''	pioyinent	<u> </u>	•
	'	_	op loss (large deductible)	j HMO contract	ĸ	PPO contract		I Indemnity	contract
	m	Ot	her (specify)						
9	•		ce-rated contracts:			T			
	a I		iums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpaid						
			ncrease (decrease) in unearned premium res	· ·			1 2 (1)		
		. ,	Earned ((1) + (2) - (3))	i		 T	. 9a(4)		
	b		efit charges (1) Claims paid						
			ncrease (decrease) in claim reserves				01 (0)		
			ncurred claims (add (1) and (2))						
	_	` '	Claims charged				. 9b(4)		
	С		nainder of premium: (1) Retention charges (o	,	0 (4)(4)	1			
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees		_ ,,,,				
			(C) Other specific acquisition costs		9c(1)(C)			_	
			(D) Other expenses		9c(1)(D) 9c(1)(E)			_	
			(E) Taxes					_	
			(F) Charges for risks or other contingencies.		0. (4)(0)			_	
			(G) Other retention charges(H) Total retention				9c(1)(H)		
			Dividends or retroactive rate refunds. (These		-				
	الم								
	d		us of policyholder reserves at end of year: (1				` '		
		` '	Claim reserves				. 9d(2)		
	_	` '	Other reserves						
10			dends or retroactive rate refunds due. (Do n erience-rated contracts:	ot include amount entered	in line 9c(2)	<u>).)</u>	9e		
10	_			porrior			. 10a		1017
	a		al premiums or subscription charges paid to c				. <u>10a</u>		12178
	b Sne	rete	e carrier, service, or other organization incuri ntion of the contract or policy, other than rep- tature of costs				. 10b		
			eature of costs.						
P	art	V	Provision of Information						
11	Dic	the	insurance company fail to provide any inform	ation necessary to compl	ete Schedule	e A?	Yes	X No	
12	2 If t	he ar	nswer to line 11 is "Yes," specify the informat	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

This Form is Open to Public

		pursuant to El	RISA section 103(a)(2).				Inspection	
For calendar plan year 20	17 or fiscal plan	year beginning 01/01/2017		and end	ding 12/3	1/2017		
A Name of plan SAMUEL A. RAMIREZ &	CO. HEALTH A	AND WELFARE BENEFITS PLAN	l	B Three	e-digit number (PN	J) •	501	
C Plan sponsor's name a SAMUEL A. RAMIREZ &		e 2a of Form 5500	[yer Identifica 2695511	ation Number (EIN)	
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca THE GUARDIAN LIFE INS		IPANY OF AMERICA						
	(c) NAIC	(d) Contract or	(e) Approximate num			Policy or co	ntract year	
(b) EIN	code	identification number	persons covered at e policy or contract y		(f)	From	(g) To	
13-5123390	64246	00483550	122		01/01/2017	7	12/31/2017	
2 Insurance fee and come descending order of the		ation. Enter the total fees and tota	I commissions paid. List	in line 3 t	he agents, l	brokers, and ot	her persons in	
(a) Total a	amount of comr	missions paid		(b) To	tal amount o	of fees paid		
		3136					0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all pe	ersons).				
	(a) Name a	nd address of the agent, broker, o		commissi	ons or fees	were paid		
KINLOCH CONSULTING	GROUP, INC.	STE 260	VILLE PARK RD) LE, NY 11747-3156					
(b) Amount of sales ar	nd base	Fees	and other commissions	paid				
commissions pai		(c) Amount	(d)) Purpose)		(e) Organization code	
	2253						3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commissi	ons or fees	were paid		
FNA INSURANCE SERVICES INC. 180 RIVER ROAD FLOOR 2 SUMMIT, NJ 07901								
(b) Amount of sales ar	nd hase	Fees	and other commissions	paid				
commissions pai		(c) Amount	(d)) Purpose)		(e) Organization code	
	883						3	

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio suoio di promini rutos				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		İ	7d	
		Deductions:	Γ			
	•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

Р	Part III Welfare Benefit Contract Information						
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ing purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ntracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b X Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unem	nlovment	h Prescription drug
	:			·	<u>-</u>	ploymont	
	• [Stop loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity contract
	m	Other (specify)					
_	_						
9	•	erience-rated contracts:		0-(4)			_
	a	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2) 9a(3)			
		(3) Increase (decrease) in unearned premium res (4) Earned ((1) + (2) - (3))	· ·			. 9a(4)	
	b	Benefit charges (1) Claims paid				., Ja(+)	
	~	(2) Increase (decrease) in claim reserves		(-)			
		(3) Incurred claims (add (1) and (2))				. 9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o					
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses					
		(E) Taxes					
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges	•			6 (4)(1)	
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These					
	d	Status of policyholder reserves at end of year: (1					
		(2) Claim reserves				. 9d(2)	
	_	(3) Other reserves				. 9d(3)	
10	e No	Dividends or retroactive rate refunds due. (Do no nexperience-rated contracts:	or include amount entered	in line 90(2)	.)	. 9e	
	a	Total premiums or subscription charges paid to c	arrier			. 10a	11557
	b	If the carrier, service, or other organization incurr				100	11007
	D	retention of the contract or policy, other than repo	, .		•	. 10b	
	Spe	cify nature of costs.	•	, ,			-
D	art	IV Provision of Information					
						Vac I	V No
11		d the insurance company fail to provide any inform		ete Schedule	e A?	Yes	X No
12	! If t	he answer to line 11 is "Yes," specify the informati	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

2017

,			ERISA section 103(a)(2)		T T		n is Open to Public Inspection
For calendar plan year 20	17 or fiscal pla	an year beginning 01/01/2017		and er	nding 12/31/2017	,	
A Name of plan SAMUEL A. RAMIREZ & CO. HEALTH AND WELFARE BENEFITS Pl			AN		ee-digit n number (PN)	>	501
C Plan sponsor's name a SAMUEL A. RAMIREZ &	CO., INC.			13-	oyer Identification N -2695511		
on a separa		erning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca XCHANGE BENEFITS	rrier						
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year		(f) From	licy or co	ntract year (g) To
13-5459190	21113	US619513			01/01/2017		12/31/2017
2 Insurance fee and composition descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, brokers	s, and ot	her persons in
(a) Total a	amount of con	nmissions paid		(b) To	otal amount of fees	paid	
(0)		62428		V-7			0
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees were p	aid	
INTERNATIONAL BENEFI	TS ADMIN		SARDEN CITY PLAZA DEN CITY, NY 11530				
(b) Amount of sales ar	nd hase	Fe	es and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose				(e) Organization code
	62428						3
	(a) Name	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees were p	paid	
(b) Amount of sales ar			ees and other commission	•			
commissions pai	id	(c) Amount		(d) Purpos	e		(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,		code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio suoio di promini rutos				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		İ	7d	
		Deductions:	Γ			
	•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

F	art	Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the ng purposes if such contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i İ	X Stop loss (large deductible)	j HMO contract	k	=	1 1	I Indemnity contract
	m	Other (specify)	,e coac.				
	"""	_ Other (specify) F					
9	Exp	erience-rated contracts:					
Ŭ		Premiums: (1) Amount received		9a(1)			_
	ŭ	(2) Increase (decrease) in amount due but unpaid.	⊢	9a(2)			_
		(3) Increase (decrease) in unearned premium rese	T T T T T T T T T T T T T T T T T T T	9a(3)			
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid	T T	9b(1)		1 7	
		(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	(
		(4) Claims charged				: :	
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)		T	
		(H) Total retention			•		(
		(2) Dividends or retroactive rate refunds. (These a	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide h	benefits afte	er retirement	9d(1)	
		(2) Claim reserves					
		(3) Other reserves				· · · · ·	
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	l in line 9c(2	2) .)	9e	
1() No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			<u>10a</u>	424792
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than report					
		ecify nature of costs.					
F	art	IV Provision of Information					
11	Die	d the insurance company fail to provide any informa	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	the answer to line 11 is "Yes," specify the information	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

		pursuant to Ef	RISA section 103(a)(2).			Inspection
For calendar plan yea	r 2017 or fiscal plar	year beginning 01/01/2017	and e	ending 12/3	31/2017	•
A Name of plan SAMUEL A. RAMIRE	EZ & CO. HEALTH /	AND WELFARE BENEFITS PLAN		ee-digit n number (P	N) •	501
C Plan sponsor's nar SAMUEL A. RAMIRE		e 2a of Form 5500		loyer Identific 3-2695511	cation Number	(EIN)
		ning Insurance Contract . Individual contracts grouped as				
1 Coverage Informat	ion:					
(a) Name of insurance		NY				
/b \ F N	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f)	From	(g) To
13-1898173	64297	460242	141	01/01/201	7	12/31/2017
2 Insurance fee and descending order of		ation. Enter the total fees and total	commissions paid. List in line	3 the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
	5503 756					
3 Persons receiving	commissions and fe	ees. (Complete as many entries a	s needed to report all persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	sions or fees	were paid	
MBL BENEFITS CON	SULTING CORP	11TH FL	ST 39TH STREET .OOR DRK, NY 10018			
(b) Amount of sale	es and base	Fees	and other commissions paid			
commission		(c) Amount	(d) Purpo	se	(e) Organization code	
400					3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	sions or fees	were paid	
WILLIS OF PENNSYL		ONE PP STE 100	G PLACE			
(b) Amount of sale	as and base	Fees	and other commissions paid			
commission		(c) Amount	(d) Purpo	se		(e) Organization code
	1776					3
Far Danamuark Bade	iotion Act Notice	see the Instructions for Form FF	300		Coho	dula A (Farm FF00) 2017

Schedule A (Form 5500)	2017	Page 2 – 1			
(a) Nar	me and address of the agent, broker,	, or other person to whom commissions or fees were paid			
WILLIS OF NEW YORK INC		BERTY ST.			
		YORK, NY 10281-0001			
	Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
3127	341	ADDITIONAL COMPENSATION	3		
(a) Nar	me and address of the agent, broker,	, or other person to whom commissions or fees were paid			
FNA INSURANCE SERVICES INC		UNNYSIDE BLVD DBURY, NY 11797			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
200	200	ADDITIONAL COMPENSATION	3		
())		, or other person to whom commissions or fees were paid			
WILLIS OF PENNSYLVANIA INC	FOUR STE 5	GATEWAY CTR 444 LIBERTY AVE			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
0	215	ADDITIONAL COMPENSATION	3		
(a) Nar	me and address of the agent, broker,	, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(0)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
commissions paid			code		
(a) Nar	me and address of the agent, broker,	, or other person to whom commissions or fees were paid			
	1	Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
	i		1		

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio suoio di promini rutos				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		İ	7d	
		Deductions:	Γ			
	•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

F	Part	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	group of employees of the group of employees of the group	racts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ber	efit and contract type (check all applicable boxes)				
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabili	tv a	Supplemental	unemplovment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	, S	=	. ,	I Indemnity contract
	m	Other (specify) ACCIDENTAL DEATH & DI	· 🗀	ļ			
_							
9		erience-rated contracts:		0-(4)	1		
	а	Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpai					_
		(3) Increase (decrease) in unearned premium re		9a(3)		00(4)	
	h	(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		/			_
		(2) Increase (decrease) in claim reserves				0h/3)	
		(3) Incurred claims (add (1) and (2))					
	_	(4) Claims charged		•••••		9b(4)	
	С	Remainder of premium: (1) Retention charges (•	00/1)/4)	1		_
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)			-
		(C) Other specific acquisition costs		9c(1)(D)			_
		(D) Other expenses		9c(1)(E)			_
		(E) Charges for risks or other contingencies		9c(1)(F)			-
		(F) Charges for risks or other contingencies (G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These					
	الد		_			` ` `	
	d	Status of policyholder reserves at end of year: (•			· · ·	
		(2) Claim reserves					
	_	(3) Other reserves				` '	
11	<u>e</u>	Dividends or retroactive rate refunds due. (Do r	not include amount entered	in line 9C(2	2) .)	9e	
11	_	nexperience-rated contracts:				100	1010
	а	Total premiums or subscription charges paid to					46160
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep cify nature of costs.					
	Эре						
F	art	V Provision of Information					_
1	l Di	the insurance company fail to provide any inform	mation necessary to compl	ete Schedu	le A?	Yes	X No
12	2 If 1	he answer to line 11 is "Yes," specify the informa	tion not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

This Form is Open to Public

		pursuant to E	RISA section 103(a)(2).				Inspection
For calendar plan year 20	17 or fiscal plar	n year beginning 01/01/2017		and en	ding 12/3	31/2017	
A Name of plan SAMUEL A. RAMIREZ &	CO. HEALTH /	AND WELFARE BENEFITS PLA	N		e-digit number (Pl	N) •	501
C Plan sponsor's name a		e 2a of Form 5500			•	cation Number ((EIN)
SAMUEL A. RAMIREZ &	CO., INC.			13-	2695511		
		rning Insurance Contract . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca FIRST UNUM LIFE INSUR		ANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
13-1898173	64297	405074	118		01/01/201	7	12/31/2017
2 Insurance fee and communication descending order of the		ation. Enter the total fees and tot	al commissions paid. Lis	st in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid						
		13					31
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all p	persons).			
	(a) Name a	and address of the agent, broker,	or other person to whon	n commiss	ions or fees	s were paid	
FNA INSURANCE SERVIC	CES INC		JNNYSIDE BLVD BURY, NY 11797				
(b) Amount of sales ar	nd base	Fee	es and other commission	s paid			
commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
13 13 ADDITIONAL COMPENSATIO				ATION			3
	(a) Name a	and address of the agent, broker,	or other person to whon	n commiss	ions or fees	s were paid	
KINLOCH CONSULTING (25 MEI STE 26	LVILLE PARK RD				
(b) Amount of sales ar	nd hase	Fee	es and other commission	s paid			
commissions pai		(c) Amount		d) Purpose	9		(e) Organization code
	0	18 A	DDITIONAL COMPENS	ATION			3
For Panerwork Reduction	n Act Notice	see the Instructions for Form !	5500			Scher	dule A (Form 5500) 2017

Schedule A (Form 5500) 2017		Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
Fees and other commissions paid (e)				
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio sado di promini ratos				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		İ	7d	
		Deductions:	Γ			
	•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

F	art	III	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individe	group of employees of the ting purposes if such conti	racts are expe	erience-rated as a unit	t. Where co	contracts cover individual	
8	Ben	efit an	nd contract type (check all applicable boxes)						
	a [_	alth (other than dental or vision)	b Dental	с	Vision		d Life insurance	
	L	_		_				봄	
	e	=	mporary disability (accident and sickness)	f ∐ Long-term disabilit	• • =	Supplemental unem	pioyment	h Prescription drug	
	'	Sto	p loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity contract	
	m	Oth	ner (specify)						
9	•		e-rated contracts:	į					
	a I		ums: (1) Amount received		9a(1)				
			crease (decrease) in amount due but unpai						
			crease (decrease) in unearned premium res				0=/4)		_
	h		arned ((1) + (2) - (3))				9a(4)		0
	b		efit charges (1) Claims paid		• • •				
			crease (decrease) in claim reservescurred claims (add (1) and (2))				9b(3)		
			laims charged				9b(3)		
	С	` '	ainder of premium: (1) Retention charges (35(4)		
	·		A) Commissions	•	9c(1)(A)				
		,	B) Administrative service or other fees						
		•	C) Other specific acquisition costs		0 (4)(0)				
		•	D) Other expenses		0 (4)(D)				
		(1	E) Taxes		9c(1)(E)				
		(1	F) Charges for risks or other contingencies.		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
			H) Total retention				9c(1)(H	1)	
		(2) D	lividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Statu	us of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)		
		(2) C	laim reserves				9d(2)		
		` '	Other reserves				9d(3)		
			lends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2) .	.)	. 9e		
1() No		erience-rated contracts:				- 40		
	а		I premiums or subscription charges paid to				10a	26	54
	b Spe	reter	e carrier, service, or other organization incur ation of the contract or policy, other than rep pature of costs				10b		
P	Spe	cify na	Provision of Information						•
		-		nation necessary to compl	ata Sahadula	Δ2 Π	Yes	X No	_
11			nsurance company fail to provide any inform		ete Schedule	A!	162	_ NO	_
14	. If th	ne an	swer to line 11 is "Yes," specify the informat	ion not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

		pursuant to L	1110A 30011011 103(a)(2).		Inspection
For calendar plan year 20°	17 or fiscal plar	year beginning 01/01/2017	an	d ending 12/31/2017	
A Name of plan SAMUEL A. RAMIREZ & CO. HEALTH AND WELFARE BENEFITS PLAN			d .	hree-digit plan number (PN)	501
C Plan sponsor's name a	s shown on line	e 2a of Form 5500	D Er	nployer Identification Number	er (EIN)
SAMUEL A. RAMIREZ &	CO., INC.			13-2695511	, ,
		ning Insurance Contract . Individual contracts grouped as			
1 Coverage Information:					
(a) Name of insurance car FIRST UNUM LIFE INSUR		NY			
	(c) NAIC	(d) Contract or	(e) Approximate number of		contract year
(b) EIN	code	identification number	persons covered at end o policy or contract year	f (f) From	(g) To
13-1898173	64297	462193	35	01/01/2017	12/31/2017
2 Insurance fee and coming descending order of the		ation. Enter the total fees and tota	Il commissions paid. List in lin	e 3 the agents, brokers, and	I other persons in
(a) Total a	amount of comr	missions paid	(k) Total amount of fees paid	
		4520			463
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all person	s).	
	(a) Name a	nd address of the agent, broker,	or other person to whom comr	missions or fees were paid	
HRH CONSULTING GROU	JP INC	#260	VILLE PARK RD LE, NY 11747-3156		
(b) Amount of sales ar	nd base	Fee	s and other commissions paid		
commissions pai		(c) Amount	(d) Pur	(e) Organization code	
	4000	333 AC	ADDITIONAL COMPENSATION 3		
	(a) Name a	nd address of the agent, broker,	or other person to whom comr	missions or fees were paid	
FNA INSURANCE SERVIC		100 SU	NNYSIDE BLVD BURY, NY 11797		
(b) Amount of sales and base Fees and other commissions paid					
commissions pai		(c) Amount	(d) Purpose		(e) Organization code
	130	130 AC	DITIONAL COMPENSATION		3

Schedule A	(Form 5500)	2017
00000.07.	(,

Dage	2.	_ [-		
Page	Z -	- 1	- 1		

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid NG CORP 323 WEST 39TH STREET 11TH FLOOR

MBL BENEFITS CONSULTING CORP

	NEW '	YORK, NY 10018	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
390			3
(a) Nar	me and address of the agent, broker,	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
policina pol			
(a) Nar	me and address of the agent, broker,	, or other person to whom commissions or fees were paid	
	ı	Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(4) 2 4	code
(a) Nar	ne and address of the agent, broker,	, or other person to whom commissions or fees were paid	
•			
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(6)76	(4) 1 8.15000	code
(a) Nar	me and address of the agent, broker,	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(o) Amount	(a) i dipose	code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio sado di promini ratos				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		İ	7d	
		Deductions:	Γ			
	•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

F	art	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reporti employees, the entire group of such individu	group of employees of the ng purposes if such contr	acts are ex	perience-rated as	a unit. Where co	ntracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental (unemplovment	h Prescription drug
	i İ	Stop loss (large deductible)	j HMO contract	k		,	I Indemnity contract
	m	Other (specify)	, 🗆				
9	Fxne	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			_
	_	(2) Increase (decrease) in amount due but unpaid	•	9a(2)			_
		(3) Increase (decrease) in unearned premium res		9a(3)			_
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)		, , ,	
		(2) Increase (decrease) in claim reserves	•	9b(2)			7
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (or				,	
		(A) Commissions		9c(1)(A)			7
		(B) Administrative service or other fees	•	9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			_
		(G) Other retention charges		9c(1)(G)			_
		(H) Total retention	-			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)		<u> </u>	<u>!</u> !		
		(2) Claim reserves	·			· · · · · · · · ·	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2	2).)		
10) No	nexperience-rated contracts:			,	•	
	а	Total premiums or subscription charges paid to ca	arrier			10a	2927
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	onnection w	ith the acquisition	or	
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.				·	
Г	or4	W Provision of Information					
	art					Пу	
11		the insurance company fail to provide any inform		ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the information	on not provided.				

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Department of Labor

Service Provider Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

2017

This Form is Open to Public Inspection.

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017	and ending 12/31/2017
A Name of plan SAMUEL A. RAMIREZ & CO. HEALTH AND WELFARE BENEFITS PLAN	B Three-digit plan number (PN)
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
SAMUEL A. RAMIREZ & CO., INC.	13-2695511
Part I Service Provider Information (see instructions)	
You must complete this Part, in accordance with the instructions, to report the information record or more in total compensation (i.e., money or anything else of monetary value) in connection plan during the plan year. If a person received only eligible indirect compensation for which the answer line 1 but are not required to include that person when completing the remainder of the	with services rendered to the plan or the person's position with the he plan received the required disclosures, you are required to
1 Information on Persons Receiving Only Eligible Indirect Compensation	on .
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this	
indirect compensation for which the plan received the required disclosures (see instructions for	, , , , , , , , , , , , , , , , , , ,
	,
b If you answered line 1a "Yes," enter the name and EIN or address of each person providing received only eligible indirect compensation. Complete as many entries as needed (see instr	
(b) Enter name and EIN or address of person who provided you disc	osures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disc	osures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disc	osures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disc	osures on eligible indirect compensation

Schedule C (Form 5500) 2017	Page 2- 1
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract	no provided you disclosures on eligible indirect compensation
(D) Enter name and EIN or address of person wh	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the control of th	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation

	Schedule C (Form 550	00) 2017		Page 3 - 1		
answered	l "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation in person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
	· · · · · · · · · · · · · · · · · · ·		(a) Enter name and EIN or	r address (see instructions)	<u> </u>	·
KINLOCH	CONSULTING INSUR		25 MEL	VILLE PARK RD LE, NY 11747		
20-833348	7					
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 53 70	INDEPENDENT BROKER	61893	Yes No 🛚	Yes No X	0	Yes No X
		(a) Enter name and EIN or	address (see instructions)		
MBL BENE 20-293041	EFITS CONSULTING	GROUP	11TH F	EST 39TH STREET LOOR ORK, NY 10018		
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 53 70	INDEPENDENT BROKER	13046	Yes No X	Yes No X	0	Yes No X
		(a) Enter name and EIN or	address (see instructions)	,	
INTERNAT	ΓΙΟΝΑL BENEFITS AL		100 GA	RDEN CITY PLAZA EN CITY, NY 11530		
11-329316	2					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	CLAIMS PROCESSOR	32666	Yes No X	Yes No X	0	Yes No X

Page	3 -	2
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answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
	, , ,	,		address (see instructions)		,
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		((a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Page	4	-	I
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Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compen or provides contract administrator, consulting, custodial, investment advisory, investment ma questions for (a) each source from whom the service provider received \$1,000 or more in ind provider gave you a formula used to determine the indirect compensation instead of an amount many entries as needed to report the required information for each source.	nagement, broker, or recordkeepinç lirect compensation and (b) each so	g services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

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D(II O 1 D		No. 20 1 1 1 1 1 1	
	oviders Who Fail or Refuse to F		
this Schedule.		h service provide	r who failed or refused to provide the information necessary to complete
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

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Schedule C (Form 5500) 2017

Pa	art III Termination Information on Accountants and Enrolled Actuaries (see in	structions)
	(complete as many entries as needed)	L =
a	Name:	b EIN:
C	Position:	
d	Address:	e Telephone:
Fx	planation:	
	prantation.	
а	Name:	b EIN:
c	Position:	EIII.
d	Address:	e Telephone:
-		
Ex	planation:	
а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:
	planation:	
LX	pianation.	
а	Name:	b EIN:
C	Position:	D LIIV.
d	Address:	e Telephone:
Ex	planation:	
a	Name:	b EIN:
C	Position:	
d	Address:	e Telephone:
	planation	
ĽΧ	planation:	

Form **5558**

(Rev. August 2012)

Signature ▶

Department of the Treasury Internal Revenue Service

Application for Extension of Time To File Certain Employee Plan Returns

► For Privacy Act and Paperwork Reduction Act Notice, see instructions.

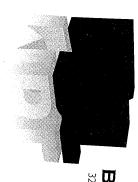
Information about Form 5558 and its instructions is at www.irs.gov/form5558

OMB No. 1545-0212

File With IRS Only

ıα	identification					
A	Name of filer, plan administrator, or plan sponsor (see instructions)	B Fil	er's identi	ifying number	see instruction	ns)
	SAMUEL A. RAMIREZ & CO., INC.	Employer identification number (EIN) (9 digits XX-XXXXX				s XX-XXXXXXX
	Number, street, and room or suite no. (If a P.O. box, see instructions)			13-2	2695511	
	61 BROADWAY, SUITE 2924	Sc	cial securi	itv number (SSI	N) (9 digits XXX-	XX-XXXX)
	City or town, state, and ZIP code			.,	, (c a.g,	, , , , , , , , , , , , , , , , , , , ,
	NEW YORK, NY 10006					
С	Plan name	P	an	Pla	n year endi	ng —
	rian name	nun	nber	MM	DD	YYYY
	SAMUEL A. RAMIREZ & CO. HEALTH AND WELFARE BENEFITS PLAN	5	0 1	12	31	2017
Par	t II Extension of Time To File Form 5500 Series, and/or Form 8	955-SSA	١			
1	Check this box if you are requesting an extension of time on line 2 to file the in Part 1, C above.	e first For	m 5500 s	series return/	report for the	plan listed
2	I request an extension of time until 1 0 /1 5 /2 0 1 8 to file Form Note. A signature IS NOT required if you are requesting an extension to file Fo		•	nstructions).		
3	I request an extension of time until/ to file Form Note. A signature IS NOT required if you are requesting an extension to file Fo			structions).		
	The application is automatically approved to the date shown on line 2 and/or the normal due date of Form 5500 series, and/or Form 8955-SSA for which and/or line 3 (above) is not later than the 15th day of the third month after the results of the shown of the show	this exte	nsion is	(a) the Form requested, a	5558 is filed and (b) the d	on or before ate on line 2
Par	Extension of Time To File Form 5330 (see instructions)					
4	I request an extension of time until/ to file Form You may be approved for up to a 6 month extension to file Form 5330, after the		due date	of Form 533	i0.	
а	Enter the Code section(s) imposing the tax	. > [_:	a			
b	Enter the payment amount attached			>	b	•
с 5	For excise taxes under section 4980 or 4980F of the Code, enter the reversion. State in detail why you need the extension:	/amendme	ent date	>	С	

Date ▶



BENEFITS CONSULTING 323 W. 39th St., 11th Floor, New York, NY 10018

Cgden, UT 84201-0045 Internal Revenue Service Center Department of the Treasury

