### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## 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 the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2017

Administration		the instructions to the Form 5500.						
Pensio	n Benefit Guaranty Corporation	_			This	Form is Open to Pu Inspection	ublic	
Part I	Annual Report Id	lentification Information						
For calen	dar plan year 2017 or fisc	al plan year beginning 04/01/201	7	and ending 04/01/20	)18			
A This r	eturn/report is for:	a multiemployer plan	participating e	oloyer plan (Filers checking the mployer information in accor			ns.)	
		X a single-employer plan	a DFE (specify	/)				
<b>B</b> This r	eturn/report is:	the first return/report	the final return	•				
		x an amended return/report	a short plan ye	ear return/report (less than 12	2 months)			
C If the	plan is a collectively-barga	ained plan, check here				•		
D Check	k box if filing under:	Form 5558	automatic exter	nsion	the	e DFVC program		
		x special extension (enter descri	ption) CONTACT CHANG	BE .				
Part II	Basic Plan Inforr	nation—enter all requested infor	mation					
1a Nam F&E AIF	e of plan RCRAFT MAINTENANCE	(MIAMI), LLC			1b	Three-digit plan number (PN) ▶	501	
					<b>1c</b> Effective date of plan 04/01/2017		an	
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)					<b>2b</b> Employer Identification Number (EIN) 52-2177585		ation	
F&E AIRO	CRAFT MAINTENANCE (I	MIAMI), LLC			2c	Plan Sponsor's tele number 305-871-3758	•	
	TH DR STE 306 PRINGS, FL 33166-5926		657 SOUTH DR STE 306 MIAMI SPRINGS, FL 33166-5926			Business code (see instructions) 811310	е	
Caution:	Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.							
	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 Filed with authorized/valid electronic signature.			11/28/2018	11/28/2018 GUY TICKNER				
HERE	Signature of plan admi	nistrator	Date	Enter name of individual s	igning as	plan administrator		
	garm p-a-r darin		2 4.0		.gg ao			
SIGN HERE								
HEIKE	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

	Form 5500 (2017)	Page <b>2</b>			
3a	Plan administrator's name and address X Same as Plan Sponsor			<b>3b</b> Administ	rator's EIN
				<b>3c</b> Administr	ator's telephone
				number	
4	If the name and/or EIN of the plan sponsor or the plan name has changed sir			<b>4b</b> EIN	
а	enter the plan sponsor's name, EIN, the plan name and the plan number from Sponsor's name	ii tile last retum/repo	it.	4d PN	
С	Plan Name				
5	Total number of participants at the beginning of the plan year			5	490
6	Number of participants as of the end of the plan year unless otherwise stated <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).	d (welfare plans comp	olete only lines 6a(1),		
a(	Total number of active participants at the beginning of the plan year			6a(1)	490
	-			, ,	490
a(	2) Total number of active participants at the end of the plan year			6a(2)	400
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	490
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits		6e	
f	Total. Add lines <b>6d</b> and <b>6e</b>			6f	490
				0.	
g	Number of participants with account balances as of the end of the plan year (complete this item)	• •	•	6g	
h	Number of participants who terminated employment during the plan year with	n accrued benefits that	at were	_	
7	less than 100% vested			6h 7	
8a	If the plan provides pension benefits, enter the applicable pension feature co				ctions:
b	If the plan provides welfare benefits, enter the applicable welfare feature code	es from the List of Pl	an Characteristics Codes	in the instruct	ions:
	4A 4D 4E 4B 4Q 4Q 4Q 4Q				
9a	Plan funding arrangement (check all that apply)		rrangement (check all tha	t apply)	
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) X	Insurance Code section 412(e)(3) i	ncuranco cont	racte
	(3) Trust	(2)	Trust	risurarice com	iacis
	(4) General assets of the sponsor	(4)	General assets of the sp	onsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at	ttached, and, where	ndicated, enter the numb	er attached. (	See instructions)
а	Pension Schedules	b General Scho	edules		
	(1) R (Retirement Plan Information)	(1)	H (Financial Inform	nation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Inform	ation – Small	Plan)
	Purchase Plan Actuarial Information) - signed by the plan	(3)	8 A (Insurance Inform	mation)	
	actuary	(4)	C (Service Provide	r Information)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	<b>D</b> (DFE/Participating	ng Plan Inform	ation)
	Information) - signed by the plan actuary	(6)	<b>G</b> (Financial Trans	action Schedu	ıles)

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.)						
<b>11b</b> 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 ERISA section 103(a)(2). Inspection						Inspection	
For calendar plan year 2017 or fiscal plan year beginning 04/01/2017 and ending 04/01/2018						1/2018	
A Name of plan F&E AIRCRAFT MAINTER			B Three-digit plan number (PN) 501				
C Plan sponsor's name as F&E AIRCRAFT MAINTEN				-	oyer Identifica 2177585	ation Number	(EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance car UMR, INC.	rier		_				
(b) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	contract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
39-1995276		76412469		•	04/01/2017	7	03/31/2018
2 Insurance fee and commodescending order of the		tion. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents,	brokers, and o	other persons in
(a) Total a	mount of comr			<b>(b)</b> To	otal amount	of fees paid	
		153815					
3 Persons receiving comm	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,		m commiss	ions or fees	were paid	
HUDSON SHORE GROUP		SUITE	FRONT ST 310 ANK, NJ 07701				
(b) Amount of sales an	d base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
							3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales an	d base	Fee	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
	A . N:						/= =====

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	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 fees 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	
<b>(a)</b> 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	
<b>(a)</b> 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>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>,                                      </u>	code	
(1)					
( <b>a)</b> 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 indivi- 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				
	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>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1)  individual policies (2)  group deferred	d annuity			
		(3) other (specify)				
	_			, n		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
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				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(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(4)			
		<b>•</b>				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

ı	Page	4

P	art	Welfare Benefit Contract In: If more than one contract covers the the information may be combined for employees, the entire group of such	same group of employees of the reporting purposes if such cor	ntracts are exp	perience-rated as a un	it. Where co	ntracts cover individual	
8	Ben	nefit and contract type (check all applicable I			<u> </u>	•	<u> </u>	
	г	Health (other than dental or vision)	<b>b</b> Dental	сГ	Vision		<b>d</b> Life insurance	
		Temporary disability (accident and sickn	<u>.</u> H	<u> </u>	<del>-</del>		h Prescription drug	
	e		· 📙 ·		=	ipioyment		
	'	Stop loss (large deductible)	j  HMO contract	K	PPO contract		I Indemnity contra	ct
	m	Other (specify)						
9	Expe	perience-rated contracts:			T		_	
	a	Premiums: (1) Amount received		· · · · ·				
		(2) Increase (decrease) in amount due but						
		(3) Increase (decrease) in unearned premi				2 (0)		
	L	(4) Earned ((1) + (2) - (3))			 I	9a(4)		
	b	3 ( )					_	
		(2) Increase (decrease) in claim reserves				01- (0)		
		(3) Incurred claims (add (1) and (2))						
	_	(4) Claims charged(1) Batastian shared				9b(4)		
	С	Remainder of premium: (1) Retention cha	• ,	00(4)(A)	1		_	
		(A) Commissions				255089	_	
		<ul><li>(B) Administrative service or other fees</li><li>(C) Other specific acquisition costs</li></ul>		0 (4)(0)		200009	_	
		(D) Other expenses		0 (4)(5)			_	
		(E) Taxes		0 (4)(=)			_	
		(F) Charges for risks or other continge						
		(G) Other retention charges		0. (4)(0)			_	
		(H) Total retention			<u> </u>	9c(1)(H)		255089
		(2) Dividends or retroactive rate refunds.	_	_				
	d							
	<u>.</u>	(2) Claim reserves	. ,					
		(3) Other reserves						
	е	Dividends or retroactive rate refunds due.						
10		onexperience-rated contracts:		,	, ,			
	а	Total premiums or subscription charges pa	aid to carrier			10a		
	b	If the carrier, service, or other organization	incurred any specific costs in	connection wi	th the acquisition or			
	-	retention of the contract or policy, other the				10b		
	Spe	ecify nature of costs.						
P	art	IV Provision of Information						
11		id the insurance company fail to provide any	information necessary to com-	olete Schedule	е А?Г	Yes	No	
		the answer to line 11 is "Yes," specify the in		oroto Ooricuult		- <del>-</del>		
14	. 11 (	the answer to line it is ites, specify the in	ioimation not provided. 🔻					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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OMB No. 1210-0110

2017

pursuant to ERISA section 103(a)(2). Inspection						Inspection	
For calendar plan year 2017 or fiscal plan year beginning 04/01/2017 and ending 04/01/2018							
A Name of plan F&E AIRCRAFT MAINTE			B Three-digit plan number (PN) 501				
C Plan sponsor's name a F&E AIRCRAFT MAINTE				-	yer Identific 2177585	ation Number (	EIN)
		ning Insurance Contrac					
on a separa  1 Coverage Information:	ate Schedule A	. Individual contracts grouped a	as a unit in Parts II and II	i can be re	ported on a	single Schedul	e A.
(a) Name of insurance ca UNITED HEALTHCARE IN		DMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
36-2739571	79413	417003412469	258	3	04/01/201	7	04/01/2018
2 Insurance fee and coming descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and of	ther persons in
(a) Total a	amount of com	missions paid		<b>(b)</b> To	tal amount	of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
THIRDON CHORE ORGHI		and address of the agent, broker		m commiss	ions or fees	were paid	
HUDSON SHORE GROUP		SUITE	7 FRONT ST : 310 BANK, NJ 07701				
(b) Amount of sales ar	nd base		es and other commission	ns paid			
commissions pai	id	(c) Amount		(d) Purpose	d) Purpose		(e) Organization code
							3
	(a) Name a	and address of the agent, broker	or other person to who	m commiss	ions or fees	were paid	
		•					
(b) Amount of sales and base Fees and other commissions paid							
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code
For Panerwork Reduction	n Act Notice	see the Instructions for Form	5500			Scher	lule A (Form 5500) 2017

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	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 fees 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	
<b>(a)</b> 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	
<b>(a)</b> 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>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>,                                      </u>	code	
(1)					
( <b>a)</b> 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 indivi- 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				
	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>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1)  individual policies (2)  group deferred	d annuity			
		(3) other (specify)				
	_			, n		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
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				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(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(4)			
		<b>•</b>				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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F	art	III Welfare Benefit Contract Informal If more than one contract covers the same to the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such conti	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental u	inemployment	h Prescription drug
	: 5		j HMO contract	, s k	=	inomproymon.	
	' <u> </u>	Stop loss (large deductible)	I HIVIO contract	ĸ	PPO contract		I Indemnity contract
	m	Other (specify)					
_	_						
9		erience-rated contracts:	1	0. (4)			_
	а	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)		00(4)	
	h	(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1) 9b(2)			_
		(2) Increase (decrease) in claim reserves				9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (o				J 35(4)	
	·	(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)			
		(H) Total retention	· · · · · · · · · · · · · · · · · · ·		1	9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)		
	d	Status of policyholder reserves at end of year: (1			1		
	-	(2) Claim reserves	•			· · · · ·	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do no					
10	) No	nexperience-rated contracts:		•	,	•	
	а	Total premiums or subscription charges paid to c	arrier			10a	56122
	b	If the carrier, service, or other organization incurr	ed anv specific costs in c	onnection w	vith the acquisition	or	
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.					
Р	art	V Provision of Information					
11	Dic	I the insurance company fail to provide any inform	ation necessary to compl	ete Schedu	le A?	Yes	X No
		he answer to line 11 is "Yes," specify the informati		22000			<u> </u>
		to allower to line 11 to 100, opening the illiointal	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

					Inspection		
For calendar plan year 20°	17 or fiscal plan	year beginning 04/01/2017		and en	iding 04/0	1/2018	
A Name of plan F&E AIRCRAFT MAINTE	NANCE (MIAM	I), LLC			e-digit number (PN	۱) 🕨	501
·	C Plan sponsor's name as shown on line 2a of Form 5500  F&E AIRCRAFT MAINTENANCE (MIAMI), LLC  D Employer Identification Number (EIN) 52-2177585						EIN)
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance call UNITED OF OMAHA LIFE		COMPANY					
/b) [IN	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
47-0322111	69868	G000AZTD	132	2	04/01/2017	7	04/01/2018
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid						
		4851					897
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
		nd address of the agent, broker,	•	m commiss	ions or fees	were paid	
HUDSON SHORE GROUP	•	SUITE 3	FRONT ST 310 ANK, NJ 07701				
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code
							3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
Fan Damamuanlı Danluştia	n Ast Nation	see the Instructions for Form F	F00			Calaaa	I.I. A (Farm FEOO) 2017

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	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 fees 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	((	code	
<b>(a)</b> 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
<b>(a)</b> 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>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> 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 indivi- 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				
	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>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1)  individual policies (2)  group deferred	d annuity			
		(3) other (specify)				
	_			, n		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
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				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(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(4)			
		<b>•</b>				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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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 individuals.	rting purposes if such cont	racts are exp	perience-rated as a uni	t. Where co	ontracts cover individual	
R	Ren	efit and contract type (check all applicable boxes		,				
٠	a	Health (other than dental or vision)	<b>b</b> Dental	сГ	Vision		<b>d</b> Life insurance	
		⊒ <b>-</b>	_	<u>_</u>			불	
	е	Temporary disability (accident and sickness)	f Long-term disabili	- 5	Supplemental unem	ployment	h Prescription drug	
	i	Stop loss (large deductible)	j  HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify) VOLUNTARY ACCIDENT I	NSURANCE					
9	Ехр	erience-rated contracts:						
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpa	id	9a(2)				
		(3) Increase (decrease) in unearned premium re	serve	9a(3)		1		
		(4) Earned ((1) + (2) - (3))			 T	. 9a(4)		
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves				1		
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (		0-(4)(A)	1			
		(A) Commissions		9c(1)(A)			_	
		(B) Administrative service or other fees		0. (4)(0)			_	
		(C) Other specific acquisition costs		0.741701			_	
		(D) Other expenses(E) Taxes		0 (4)(5)				
		(F) Charges for risks or other contingencies					_	
		(G) Other retention charges					_	
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (Thes	_					
	d	Status of policyholder reserves at end of year: (	_	_		9d(1)		
	-	(2) Claim reserves	,			9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do r						
10	No	nexperience-rated contracts:		•				
	а	Total premiums or subscription charges paid to	carrier			. 10a	41007	
	b	If the carrier, service, or other organization incur	rred any specific costs in c	onnection wi	th the acquisition or			
	_	retention of the contract or policy, other than rep	oorted in Part I, line 2 abov	e, report am	ount	10b		
	Spe	cify nature of costs.						
P	art	V Provision of Information						
			motion necessarity as and	oto Celesalel	- Д2	Yes	X No	
11		the insurance company fail to provide any inform		ete Schedule	e A?	169	<u> </u>	
12	. If t	ne 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

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 20	17 or fiscal plan	year beginning 04/01/2017		and en	ding 04/0	1/2018	
A Name of plan F&E AIRCRAFT MAINTE	NANCE (MIAM	I), LLC		<b>B</b> Three	e-digit number (PN	N) <b>•</b>	501
C Plan sponsor's name as shown on line 2a of Form 5500  F&E AIRCRAFT MAINTENANCE (MIAMI), LLC  D Employer Identification Number (EIN) 52-2177585						EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number		ons covered at end of licy or contract year		From	<b>(g)</b> To
47-0322111	69868	G000AZTD	139		04/01/2017	7	04/01/2018
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) Total amount of commissions paid (b) Total amount of fees paid					000		
		2823					622
3 Persons receiving com		ees. (Complete as many entries					
LILIDOON OLIODE ODOLIE		nd address of the agent, broker,		n commiss	ions or fees	were paid	
HUDSON SHORE GROUP		SUITE:	FRONT ST 310 ANK, NJ 07701				
(b) Amount of sales ar	nd base	Fee	s and other commissior	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code
							3
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
		_				·	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code
	A 4 NI 41						/= =====

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	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 fees 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	((	code	
<b>(a)</b> 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
<b>(a)</b> 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>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
( <b>a)</b> 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 indivi- 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				
	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>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1)  individual policies (2)  group deferred	d annuity			
		(3) other (specify)				
	_			, _		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
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				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(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(4)			
		<b>•</b>				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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P	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 individuals.	rting purposes if such cont	racts are exp	perience-rated as a uni	t. Where co	ontracts cover individual
R	Bor	efit and contract type (check all applicable boxes				a.poooo o. t	
U	a	Health (other than dental or vision)	<b>b</b> Dental	сГ	Vision		<b>d</b> Life insurance
			. H	<u>_</u>			
	е	Temporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	ployment	h Prescription drug
	i	Stop loss (large deductible)	j 📗 HMO contract	k	PPO contract		I Indemnity contract
	m	X Other (specify) ► VOLUNTARY CRITICAL IL	LNESS				
9	Exp	erience-rated contracts:			1		
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpai					
		(3) Increase (decrease) in unearned premium re				0.74	
		(4) Earned ((1) + (2) - (3))			 T	. 9a(4)	
	b	Benefit charges (1) Claims paid		a. (a)			
		(2) Increase (decrease) in claim reserves				0h/2\	
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3) . 9b(4)	
	С	(4) Claims charged			•••••	. 3b(4)	
	·	(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		- (1)(T)			
		(C) Other specific acquisition costs		0 (4)(0)			
		(D) Other expenses		0 (4)(D)			
		(E) Taxes		0. (4)(5)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges					
		(H) Total retention				. 9c(1)(H)	)
		(2) Dividends or retroactive rate refunds. (Thes	e amounts were 🗌 paid ir	n cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (	1) Amount held to provide	benefits afte	r retirement	. 9d(1)	
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves				. 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do r	not include amount entered	d in line <b>9c(2</b> )	<u>)</u> .)	9e	
10	_	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to				. <u> </u>	21843
	b	If the carrier, service, or other organization incur			•	. 10b	
	Spe	retention of the contract or policy, other than repartity nature of costs.	orted in Part I, line 2 abov	e, report am	ount	. 100	
	Ċ	,					
Р	art	IV Provision of Information					_
11	l Di	the insurance company fail to provide any inform	nation necessary to comp	lete Schedule	e 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

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 201	17 or fiscal plan	year beginning 04/01/2017		and en	ding 04/0	1/2018	
A Name of plan F&E AIRCRAFT MAINTE	NANCE (MIAM	I), LLC		<b>B</b> Thre	e-digit number (PN	N) <b>•</b>	501
•	C Plan sponsor's name as shown on line 2a of Form 5500  F&E AIRCRAFT MAINTENANCE (MIAMI), LLC  D Employer Identification Number (EIN) 52-2177585						EIN)
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance car AETNA LIFE INSURANCE							
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number		persons covered at end of policy or contract year		From	<b>(g)</b> To
06-6033492		0773068	576	5	04/01/2017	7	04/01/2018
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) Total amount of commissions paid (b) Total amount of fees paid							
		7416					
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,		m commiss	ions or fees	were paid	
HUDSON SHORE GROUP		SUITE	FRONT ST 310 ANK, NJ 07701				
(b) Amount of sales an	d base	Fee	s and other commission	ns paid			
commissions pai	d	(c) Amount		(d) Purpos	Э		(e) Organization code
							3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
		•	·			·	
(b) Amount of sales an	d base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code
	A 4 NI 41						/= =====\ /==

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	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 fees 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
<b>(a)</b> 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
<b>(a)</b> 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>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> 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 indivi- 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				
	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>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1)  individual policies (2)  group deferred	d annuity			
		(3) other (specify)				
	_			, _		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
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				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(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(4)			
		<b>•</b>				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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P	art	If th	<b>/elfare Benefit Contract Inform</b> more than one contract covers the same e information may be combined for repornployees, the entire group of such indivices.	group of employees of the ting purposes if such conti	racts are expe	erience-rated as a unit	. Where co	ontracts cover individual
8	Ben		contract type (check all applicable boxes)					
Ŭ	a [	_	n (other than dental or vision)	<b>b</b> X Dental	с	Vision		<b>d</b> Life insurance
	 F	<u> </u>		- H		!		_
	е	=	orary disability (accident and sickness)	f ∐ Long-term disabilit	• • =	Supplemental unemp	ployment	h Prescription drug
	i	Stop I	oss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity contract
	m	Other	(specify)					
		_						
9	Ехре	erience-r	ated contracts:					
	a I	Premium	s: (1) Amount received		9a(1)			
		(2) Incre	ease (decrease) in amount due but unpai	d				
			ease (decrease) in unearned premium res					
			ned ( <b>(1) + (2) - (3)</b> )				9a(4)	
	b		charges (1) Claims paid					
			ease (decrease) in claim reserves				21 (2)	
			rred claims (add (1) and (2))				9b(3)	
		` '	ms charged		•••••		9b(4)	
	С		nder of premium: (1) Retention charges (c	•	0-(4)(4)			_
		` '	Commissions					
		` '	Administrative service or other fees		0 (4)(0)			
		. ,	Other specific acquisition costs  Other expenses		0 (4)(5)			
		` '	Taxes		0 (4)(5)			
			Charges for risks or other contingencies.					
		(G)	Other retention charges		9c(1)(G)			
			Total retention				9c(1)(H)	)
		` '	dends or retroactive rate refunds. (These		_			
	d		of policyholder reserves at end of year: (1				9d(1)	
	_		m reserves	•			9d(2)	
		` '	er reserves				9d(3)	
	е	` '	ds or retroactive rate refunds due. (Do n				9e	
10			ence-rated contracts:		` '	,	•	
	а	Total pr	remiums or subscription charges paid to	carrier			10a	194417
	b		arrier, service, or other organization incur in of the contract or policy, other than rep				. 10b	
Б		cify natu	re of costs.					
	art l		Provision of Information					П
11			urance company fail to provide any inforn		ete Schedule	A?	Yes	X No
12	2 If the	he answ	er 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

OMB No. 1210-0110

2017

		pursuant to E	RISA section 103(a)(2).			11110 1 011	Inspection	
For calendar plan year 20	17 or fiscal plan	year beginning 04/01/2017		and en	ding 04/0	1/2018		
A Name of plan F&E AIRCRAFT MAINTE	NANCE (MIAM	I), LLC		B Three	e-digit number (PN	N) <b>•</b>	501	
	C Plan sponsor's name as shown on line 2a of Form 5500  F&E AIRCRAFT MAINTENANCE (MIAMI), LLC  D Employer Identification Number (EIN) 52-2177585							
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca UNITED OF OMAHA LIFE		COMPANY						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year	
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To	
47-0322111	69868	G000AZTD	125		04/01/2017	7	04/01/2018	
2 Insurance fee and com- descending order of the		ation. Enter the total fees and total	ıl commissions paid. Lis	st in line 3	the agents,	brokers, and ot	her persons in	
(a) Total a	amount of comm			<b>(b)</b> To	tal amount	of fees paid		
		6337					1150	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all p	persons).				
		nd address of the agent, broker, o	•		ions or fees	were paid		
HUDSON SHORE GROUP	•		ST FRONT STREET SI NK, NJ 07701	UITE 310				
(b) Amount of sales ar	nd base	Fees	s and other commission	s paid				
commissions pa		(c) Amount	(	d) Purpose	9		(e) Organization code	
							3	
	(a) Name a	nd address of the agent, broker,	or other person to whon	n commiss	ions or fees	were paid		
						·		
(b) Amount of sales ar	nd base	Fees	s and other commission	s paid				
commissions pa		(c) Amount	(	(d) Purpose			(e) Organization code	

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	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 fees 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
<b>(a)</b> 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
<b>(a)</b> 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>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
( <b>a)</b> 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 indivi- 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				
	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>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1)  individual policies (2)  group deferred	d annuity			
		(3) other (specify)				
	_			, _		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
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				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(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(4)			
		<b>•</b>				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

ı	Page	4

P	art l	III Welfare Benefit Contract Informa	ition					
		If more than one contract covers the same of the information may be combined for reportional employees, the entire group of such individual.	ng purposes if such cont	acts are expe	erience-rated as a unit	t. Where co	ontracts cover individua	
8	Bene	efit and contract type (check all applicable boxes)			<u> </u>		i	
	аΓ	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insurance	
	느	Temporary disability (accident and sickness)	f Long-term disabilit	<u> </u>	Supplemental unem	nlovenont	h Prescription drug	_
	e [		<u> </u>	·		pioymem		
	! [	Stop loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity contra	ict
	m	X Other (specify) ► VOLUNTARY LIFE						
		erience-rated contracts:	ı					
		Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium reso	· ·	9a(3)		0.74		
	_	(4) Earned ((1) + (2) - (3))				9a(4)		
		Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves	· ·			01- (0)		
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (or		00(1)(A)				
		(A) Commissions		9c(1)(A) 9c(1)(B)				
		(B) Administrative service or other fees		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		0 (4)(=)				
		(F) Charges for risks or other contingencies						
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention	•			9c(1)(H)	1	
		(2) Dividends or retroactive rate refunds. (These						
	d	Status of policyholder reserves at end of year: (1)	_			9d(1)		
	_	(2) Claim reserves	•			9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no						
10		onexperience-rated contracts:			•			
	а	Total premiums or subscription charges paid to ca	arrier			10a		53410
	b	If the carrier, service, or other organization incurre	ed any specific costs in c	onnection wit	h the acquisition or			
	_	retention of the contract or policy, other than repo	rted in Part I, line 2 abov	e, report amo	ount	. 10b		
	Spe	cify nature of costs.						
P	art I	IV Provision of Information						
					т.	Voc	V No	
		d the insurance company fail to provide any inform		ete Schedule	e A?	Yes	X No	
12	If th	he answer to line 11 is "Yes," specify the information	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).

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▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

		pursuant to E	RISA section 103(a)(2).	-		11110 1 011	Inspection	
For calendar plan year 20	17 or fiscal plan	year beginning 04/01/2017		and en	ding 04/0	1/2018		
A Name of plan F&E AIRCRAFT MAINTE	NANCE (MIAM	I), LLC		<b>B</b> Three	e-digit number (PN	N) <b>•</b>	501	
	C Plan sponsor's name as shown on line 2a of Form 5500  F&E AIRCRAFT MAINTENANCE (MIAMI), LLC  D Employer Identification Number (EIN) 52-2177585							
		ning Insurance Contract Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca UNITED OF OMAHA LIFE		COMPANY						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year	
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To	
47-0322111	69868	G000AZTD	490		04/01/2017	7	04/01/2018	
2 Insurance fee and com- descending order of the		ation. Enter the total fees and total	al commissions paid. Li	st in line 3	the agents,	brokers, and ot	her persons in	
(a) Total a	amount of comr			<b>(b)</b> To	tal amount	of fees paid		
		7608					1406	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all p	persons).				
		nd address of the agent, broker,		n commiss	ions or fees	were paid		
HUDSON SHORE GROUP		SUITE :	ST FRONT STREET 310 ANK, NJ 07701					
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid				
commissions pa		(c) Amount	(d) Purpose				(e) Organization code	
							3	
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid		
						·		
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code	
					· ·			

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	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 fees 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
<b>(a)</b> 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
<b>(a)</b> 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>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
( <b>a)</b> 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 indivi- 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				
	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>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		•		
	е	Type of contract: (1)  individual policies (2)  group deferred	d annuity			
		(3) other (specify)				
	_			, _		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
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				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(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(4)			
		<b>•</b>				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

ı	Page	4

Р	art	Welfare Benefit Contract Informatio If more than one contract covers the same grou the information may be combined for reporting p employees, the entire group of such individual of	p of employees of the ourposes if such contra	acts are expe	erience-rated as a un	it. Where co	ontracts cover individual	
8	Ren	enefit and contract type (check all applicable boxes)			,			
Ŭ	a	Health (other than dental or vision)	Dental	сГ	Vision		<b>d</b> X Life insurance	
				_			<b>=</b>	
	е	Temporary disability (accident and sickness)	Long-term disability	⁄ g <u></u>	Supplemental unem	nployment	h Prescription drug	
	i	Stop loss (large deductible)	HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)						
		_						
9	Ехр	perience-rated contracts:	_					
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium reserve		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)		1		
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on an	· -	1				
		(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	<u> </u>	9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges				00(4)(H)	<u> </u>	
		(H) Total retention					)	
		(2) Dividends or retroactive rate refunds. (These amo		_				
	d	, , , , , , , , , , , , , , , , , , , ,	·					
		(2) Claim reserves						
	_	(3) Other reserves				9d(3)		
10	e		ciude amount entered	in line 9c(2).	.)	9e		
10	_	lonexperience-rated contracts:				10a	7/	2070
	a					<u>10a</u>	70	5079
	<b>b</b> Sne	retention of the contract or policy, other than reported				10b		
	Spe	pecify nature of costs.						
Р	art	IV Provision of Information						_
		Did the insurance company fail to provide any information	n necessary to comple	ete Schedule	А?	Yes	X No	
		the answer to line 11 is "Yes," specify the information n		20.100010		1	Н	
	'	and and the mile in the independent and intermitation in						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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OMB No. 1210-0110

2017

pursuant to ERISA section 103(a)(2).					Inspection			
For calendar plan year 20	17 or fiscal plan	year beginning 04/01/2017		and en	ding 04/0	1/2018		
A Name of plan F&E AIRCRAFT MAINTE	NANCE (MIAM	II), LLC		B Three	e-digit number (PN	I) <b>•</b>	501	
C Plan sponsor's name a F&E AIRCRAFT MAINTE				-	oyer Identifica 2177585	ation Number	(EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca		THE FIDELITY SECURITY LIF	Ē					
a > =	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year	
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To	
43-0949844	71870	100578310011002	456	6	04/01/2017	7	04/01/2018	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents, l	brokers, and c	ther persons in	
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount o	of fees paid		
		4582						
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
HUDSON SHORE GROUP		SUITE	FRONT ST 310 ANK, NJ 07701					
(b) Amount of sales ar	nd hase	Fee	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose		(e) Organization code		
							3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
(b) Amount of sales and base Fees and other commissions paid								
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code	

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	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	(0	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	Г			1	
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	((	d) Purpose	code	
<b>(a)</b> Na	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	(c) Amount		d) Purpose	Organization	
commissions paid	(0)	,		code	
<b>(a)</b> 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		d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	idual contrac	ts with each carrier may	be treated	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		ŀ	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)				
	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 se	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ite participati	on guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		(*) 🗋 3***********************************				
	b	Palance at the and of the provious year		Ī	7b	
	C	Balance at the end of the previous year	7c(1)		70	
	C	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year				
		(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)).			7d	
	е	Deductions:				
		(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(4)			
		<b>\</b>				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

ı	Page	4

Р	art	III Welfare Benefit Contract Inform	ation					
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual to the contract of the same than the contract covers the same that the contract covers the same that the covers the contract covers the same that the covers the covers the same that the covers the covers the same that the covers	ting purposes if such cont	racts are exp	perience-rated as a un	it. Where co	ontracts cover individual	
8	Ben	efit and contract type (check all applicable boxes)		-	·		·	
	а	Health (other than dental or vision)	<b>b</b> Dental	c 5	X Vision		<b>d</b> Life insurance	
	L			<u> </u>	<b>=</b>	anla, mant	<u> </u>	
	e	Temporary disability (accident and sickness)	f Long-term disabilit	- 5	Supplemental unen	іріоуттепі	h Prescription drug	
	İ	Stop loss (large deductible)	j  HMO contract	k [	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Exp	erience-rated contracts:		•	1			
	а	Premiums: (1) Amount received	ļ	9a(1)				
		(2) Increase (decrease) in amount due but unpai	b	9a(2)				
		(3) Increase (decrease) in unearned premium res	serve	9a(3)				
		(4) Earned ((1) + (2) - (3))	i		 T	9a(4)		
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))						
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (c	· · · · · · · · · · · · · · · · · · ·		1			
		(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.					_	
		(G) Other retention charges	•			0o/1\/LI\	<b>\</b>	
		(H) Total retention					)	
		(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				· · · ·		
40	<u>e</u>	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2	<u>).)</u>	9e		
10	_	nexperience-rated contracts:				100		10.44
	a	Total premiums or subscription charges paid to				<u>10a</u>	44	1040
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep				10b		
	Spe	city nature of costs.	onted in Part I, line 2 abov	e, report am	ount	100		
		,						
P	art	IV Provision of Information						
			notion nocessarily and	oto Calandal	- A2	Yes	X No	
11		d the insurance company fail to provide any inform		ete Schedul	e A?	162	NU NU	
12	. If t	12 If the answer to line 11 is "Yes," specify the information not provided.						

#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor

# 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

Employee Benefits Security Administration		the instructions to the Form 5500.			
Рель	on Benefit Guaranty Corporation				This Form is Open to Public Inspection
Part	Annual Report Ide	ntification Information		1200	
For cale	ndar plan year 2017 or fiscal	plan year beginning 04/01/2017		and ending 04/01/20	18
A This	return/report is for:	a multiemployer plan  a single-employer plan	participating e		is box must attach a list of lance with the form instructions.)
R This	return/report is:	the first return/report	a DFE (specify the final return		
D 11113	тештиероц 15.	an amended return/report	_	rreport ear return/report (less than 12	months)
C If the	plan is a collectively-bargain	ned plan, check here			• []
D Chec	k box if filing under:	Form 5558	automatic exter	nsion	the DFVC program
	X	special extension (enter description	CONTACT CHANG	SE .	
Part I	Basic Plan Informa	ation—enter all requested information	)D		
	ne of plan RCRAFT MAINTENANCE (N	And the second s			1b Three-digit plan number (PN) > 501
		500. DE		8 <b>8</b>	1c Effective date of plan 04/01/2017
Maii City	ing address (Include room, a or town, state or province, or	If for a single-employer plan) pl., suite no. and street, or P.O. Box) ountry, and ZIP or foreign postal code	(if foreign, see Instr	uctions)	2b Employer Identification Number (EIN) 52-2177585
F&E AIR	CRAFT MAINTENANCE (MI.	AMI), LLC	•		2c Plan Sponsor's telephone number 305-871-3758
657 SOL MIAMI S	ITH DR STE 306 PRINGS, FL 33168-5926	657 SOUT MIAMI SPI	H DR STE 306 RINGS, FL 33168-59	26	2d Business code (see instructions) 811310
102701	- <u>-</u>				
Caution	: A penalty for the late or in	ncomplete filing of this return/repor	t will be assessed (	inless reasonable cause is	established.
Under pe	analties of periury and other t	penalties set forth in the instructions, I as the electronic version of this return	declare that I have	examined this return/report in	ciudina accompamina echadulas
SIGN HERE	Jugar	lm	11/24/14	GoyTI	ctne
	Signature of play adminis	strator	Date	Enter name of individual sig	ning as plan administrator
SIGN HERE	· ·				
	Signature of employer/pla	in sponsor	Date	Enter name of individual sig	ning as employer or plan sponsor
SIGN		2			2000
HERE	Signature of DFE	a de la companya de l	Date	Enter name of individual sig	ning as DEE
For Dan	STUDY Poduction Act Notice	a coatha tretavallana for Form CC	200	miner marine of morningal and	inig as DEE

Form 5500 (2017) v. 170203

#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### 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 the instructions to the Form 5500. OMB Nos. 1210-0110 1210-0089

2017

Administration Pension Benefit Guaranty Corporation		the instructions to the Form 5500.					
					This Form is Open to Pu Inspection	iblic	
Part I		entification Information					
For caler	ndar plan year 2017 or fisca	el plan year beginning 04/01/2017		and ending 04/01/2	018		
A This return/report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.						ns.)	
		X a single-employer plan     □	a DFE (specif				
B This r	etum/report is:	X the first return/report	the final return	900301\$4030000			
		an amended return/report	a short plan y	ear return/report (less than 1	2 months)		
C If the	plan is a collectively-barga	ined plan, check here					
D Chec	k box if filing under:	Form 5558	automatic exte	nsion	the DFVC program		
		X special extension (enter description	n) CONTACT CHANG	GE .	<del>2 1</del> .		
Part II	Basic Plan Inform	nation—enter all requested informat	ion				
1a Nam	ie of plan RCRAFT MAINTENANCE (				1b Three-digit plan number (PN) ▶	501	
		············ <b>/</b> , ===			1c Effective date of pla 04/01/2017	an	
Maili City	ing address (include room, or town, state or province,	r, if for a single-employer plan) apt., suite no. and street, or P.O. Box country, and ZIP or foreign postal cod	i) de (if foreign, see insti	ructions)	2b Employer Identifica Number (EIN) 52-2177585	[2] 다시 아시아 - [2] [2] 시아 시	
F&E AIR	CRAFT MAINTENANCE (N	(IAMI), LLC			2c Plan Sponsor's telephone number 305-871-3758		
	TH DR STE 306 PRINGS, FL 33166-5926		TH DR STE 306 PRINGS, FL 33166-5	2d Business code (see instructions) 811310	ė		
						,	
Caution	A penalty for the late or	incomplete filing of this return/repo	ort will be assessed	unless reasonable cause i	s established.		
		r penalties set forth in the instructions, Il as the electronic version of this retu					
SIGN							
HERE	Signature of plan admin	istrator	Date	Enter name of individual s	signing as plan administrator		
	J		1				
SIGN							
HERE	Signature of employer/p	olan sponsor	Date	Enter name of individual s	signing as employer or plan sp	onsor	
SIGN							
HERE							
	Signature of DFE		Date	Enter name of individual s	signing as DFE		

.03	Form 5500 (2017)	Page 2	
3a	Plan administrator's name and address X Same as Plan Sponsor		3b Administrator's EIN
			3c Administrator's telephone number
4	If the name and/or EIN of the plan sponsor or the plan name has changed senter the plan sponsor's name, EIN, the plan name and the plan number from		4b EIN
a	Sponsor's name Plan Name		4d PN
5	Total number of anticipate at the beginning of the plan uses		1 = 1
6	Total number of participants at the beginning of the plan year  Number of participants as of the end of the plan year unless otherwise state 6a(2), 6b, 6c, and 6d).	ed (welfare plans complete only lines 6a(1),	5 490
a(	Total number of active participants at the beginning of the plan year		6a(1) 490
a(	2) Total number of active participants at the end of the plan year		6a(2) 490
b	Retired or separated participants receiving benefits		6b
C	Other retired or separated participants entitled to future benefits		6c
d	Subtotal. Add lines 6a(2), 6b, and 6c		6d 490
е	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive benefits	6e
f	Total. Add lines 6d and 6e		6f 490
g	Number of participants with account balances as of the end of the plan year complete this item)		6g
h	Number of participants who terminated employment during the plan year wi		
7	less than 100% vested		6h 7
8a	If the plan provides pension benefits, enter the applicable pension feature of		
b	If the plan provides welfare benefits, enter the applicable welfare feature co	des from the List of Plan Characteristics Codes	s in the instructions:
0-	comprese no denote accountair paracestra, socialistas sicialistas de debitos. Périos se	lob succession	413
эа	Plan funding arrangement (check all that apply)  (1) X Insurance	9b Plan benefit arrangement (check all the (1) X Insurance	ат арріу)
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)	insurance contracts
	(3) Trust	(3) Trust	
10	(4) General assets of the sponsor  Check all applicable boxes in 10a and 10b to indicate which schedules are	(4) General assets of the spatial decided and where indicated, enter the number	90.948.95.C (20)
	8:5		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
а	Pension Schedules (1) R (Retirement Plan Information)	b General Schedules (1) H (Financial Inforr	nation)
		4945-C	nation Small Plan)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(3) X 8 A (Insurance Infor	68 (1922 - 1923 ) (1924 - 1922 - 1924 ) (1926
	Purchase Plan Actuarial Information) - signed by the plan actuary	(4) C (Service Provide	25
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		ng Plan Information)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(6) G (Financial Trans	2007 BERTON BERTON BE

·	Form 5500 (2017)	Page 3	
Part III	Form M-1 Compliance Information (to b	e completed by welfare benefit plans)	<u></u>
11a If the 2520	plan provides welfare benefits, was the plan subject to .101-2.) Yes 🗓 No	the Form M-1 filing requirements during the plan year? (Se	e instructions and 29 CFR
If "Ye	es" is checked, complete lines 11b and 11c.	9	
11b is the	e plan currently in compliance with the Form M-1 filing r	requirements? (See instructions and 29 CFR 2520.101-2.)	
Rece		I annual report. If the plan was not required to file the 2017 at was required to be filed under the Form M-1 filing required to rejection as incomplete.)	
Reco	eipt Confirmation Code		