Form 5500 Annual Return/Report of Employee Benefit Plan				OMB Nos. 12 12	10-0110
Department of the Treasury	and 4065 of the Employee Retireme	employee benefit plans under sections 104 nt Income Security Act of 1974 (ERISA) and the Internal Revenue Code (the Code).			
Internal Revenue Service		, , , , , , , , , , , , , , , , , , ,		2017	
Employee Benefits Security Administration	<ul> <li>Complete all entries in accordance with the instructions to the Form 5500.</li> </ul>				
Pension Benefit Guaranty Corporation			This	Form is Open to Pu Inspection	ıblic
Part I Annual Report Ide	entification Information				
For calendar plan year 2017 or fiscal	plan year beginning 07/01/2017	and ending 06/30/20	018		
A This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking t participating employer information in accor			ns.)
	X a single-employer plan	a DFE (specify)			
<b>B</b> This return/report is:	X the first return/report	the final return/report			
an amended return/report a short plan year return/report (less than 1				12 months)	
<b>C</b> If the plan is a collectively-bargair	ned plan, check here			• 🗆	
	Form 5558		_		
D Check box if filing under:		automatic extension		e DFVC program	
	special extension (enter description)				
	ation—enter all requested information				
<b>1a</b> Name of plan KNIGHT PARTNERS LLC EMPLOY	YEE WELFARE BENEFIT PLAN			Three-digit plan number (PN) ►	501
			1c	Effective date of pla 07/01/2017	an
City or town, state or province, c	, if for a single-employer plan) apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code (	if foreign, see instructions)	2b	Employer Identifica Number (EIN) 37-1379618	tion
KNIGHT PARTNERS LLC MELISSA MULHERN			2c	Plan Sponsor's tele number 312-577-3300	phone
221 N LA SALLE ST STE 300 CHICAGO, IL 60601-1211		ALLE ST STE 300 L 60601-1211	2d	Business code (see instructions) 541330	Э

### 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 HERE	Filed with authorized/valid electronic signature.	01/17/2019	MELISSA MULHERN
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	01/17/2019	MELISSA MULHERN
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2017) v. 170203

	Form 5500 (2017) Page <b>2</b>		
3a	Plan administrator's name and address 🗙 Same as Plan Sponsor	3b Ad	ministrator's EIN
			ministrator's telephone mber
4	If the name and/or FIN of the plan approach of the plan name has also also the last return/report filed for this plan	<b>4b</b> EI	N
4	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:	40 EI	IN .
a c	Sponsor's name Plan Name	<b>4d</b> PN	J
5	Total number of participants at the beginning of the plan year	5	128
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).		
a(	1) Total number of active participants at the beginning of the plan year	6a(1)	128
a(	2) Total number of active participants at the end of the plan year	6a(2)	131
b	Retired or separated participants receiving benefits	6b	C
С	Other retired or separated participants entitled to future benefits	6c	C
d	Subtotal. Add lines 6a(2), 6b, and 6c	6d	131
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e	
f	Total. Add lines 6d and 6e.	6f	131
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	с
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	0
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4E 4F 4H

9a	Plan fundin	g arrangement (check all that apply)	9b	b Plan benefit arrangement (check all that apply)			
	(1) X	Insurance		(1)	X	Insurance	
	(2)	Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts	
	(3)	Trust		(3)		Trust	
	(4)	General assets of the sponsor		(4)		General assets of the sponsor	
10	<b>0</b> Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)						

a Pens	a Pension Schedules					edule	es
(1)		R (Retirement Plan Information)		(1)	X		H (Financial Information)
(2)		MP (Multiamplayer Defined Papefit Disp and Cartain Manay		(2)			I (Financial Information – Small Plan)
(2)		<b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan		(3)	X	4	A (Insurance Information)
		actuary		(4)	X		C (Service Provider Information)
(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)			D (DFE/Participating Plan Information)
		Information) - signed by the plan actuary		(6)			<b>G</b> (Financial Transaction Schedules)

Page 3

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)			
2520.	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.) If "Yes" is checked, complete lines 11b and 11c.			
11b Is the	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.)			

Receipt Confirmation Code\_\_\_\_\_

SCHEDULE (Form 5500		Insurai	nce Informatio	n		OM	1B No. 1210-0110
Department of the Treas Internal Revenue Servi	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2017
Department of Labor Employee Benefits Security Ad		istration File as an attachment to Form 5500.					
Pension Benefit Guaranty Co	prporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This For	m is Open to Public Inspection	
For calendar plan year 20	17 or fiscal plan	year beginning 07/01/2017		and en	nding 06/3	80/2018	•
A Name of plan KNIGHT PARTNERS LLC EMPLOYEE WELFARE BENEFIT PLAN				e-digit number (Pl	N) 🕨	501	
C Plan sponsor's name a KNIGHT PARTNERS LLC		2a of Form 5500			oyer Identific 1379618	ation Number	(EIN)
		ning Insurance Contrac Individual contracts grouped					
<b>1</b> Coverage Information:							
(a) Name of insurance ca BLUE CROSS BLUE SHIE		S	(e) Approximate nu	umber of	1	Deliev or e	optropt your
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a		(6)	From	ontract year (g) To
			policy or contrac		.,		
36-1236610	70670	97193	277	7	07/01/201	7	06/30/2018
2 Insurance fee and com descending order of the		tion. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
<b>(a)</b> Total a	amount of comm	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
		79695					
3 Persons receiving com	missions and fe	es. (Complete as many entrie	es as needed to report all	persons).			
		nd address of the agent, broke	· · ·	m commiss	ions or fees	were paid	
MESIROW INSURANCE S	BERVICES		N CLARK ST AGO, IL 60654				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions paid (c) Amount (d)		(d) Purpos	e		(e) Organization code		
	76845	2850	SPECIAL PROGRAMS				3
	(a) Name ar	nd address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
			and other commission				

(b) Amount of sales and base	Fees a		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	e, see the Instructions for Form 550	0.	Schedule A (Form 5500) 2017
			v. 170203

#### (a) Name 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
			<u> </u>

(a) Name 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

(a) Name 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	<b>(c)</b> Amount	(d) Purpose	Organization code

(a) Name 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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	

Schedule A (Form 5500) 2017

	Schedule A (Form 5500) 2017	Page <b>3</b>		
Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	vidual contracts with each carri	er may be treated as a unit f	or purposes of
<b>4</b> Cur	rent value of plan's interest under this contract in the general account at year	end		
<b>5</b> Cur	rent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Cor	tracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier			
С	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
	Specify nature of costs			
_				
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts	)	
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year			
С	Additions: (1) Contributions deposited during the year	7c(1)	<b>I</b>	
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)			
	$\mathbf{b}$			
	(6)Total additions			
Ь	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).			
_	Deductions:			
Ŭ	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(2) Administration charge made by carrier			
	(4) Other (specify below)			
	,			
			7.(5)	
4	(5) Total deductions			
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7</b> f	

Ρ	art I		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					
8	Bene	efit a	nd contract type (check all applicable boxes)		,	· · ·		
	-	_	ealth (other than dental or vision)	<b>b</b> Dental	с	Vision		d Life insurance
	e	_	, ,	f Long-term disabilit	y g	Supplemental unemp	lovment	<b>h</b> Prescription drug
		_					Joyment	
		_	op loss (large deductible)	<b>j</b> HMO contract	k	PPO contract		I Indemnity contract
	m	Ot	her (specify)					
9			ce-rated contracts:	Γ	- (I)			_
			iums: (1) Amount received		9a(1)			_
		• •	ncrease (decrease) in amount due but unpaid		9a(2)			_
		• •	ncrease (decrease) in unearned premium reso	•	9a(3)		0.(1)	
	-	``	Earned ((1) + (2) - (3))				9a(4)	
			efit charges (1) Claims paid		9b(1)			-
		• •	ncrease (decrease) in claim reserves	L	9b(2)		0h/2)	
			ncurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3) 9b(4)	
			Claims charged nainder of premium: (1) Retention charges (or				30(4)	
	C		(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	······			9c(1)(H)	
		(2) [	Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d		us of policyholder reserves at end of year: (1)				9d(1)	
			Claim reserves				9d(2)	
		(3) (	Other reserves				9d(3)	
	е	Divi	dends or retroactive rate refunds due. (Do no	t include amount entered	l in line <b>9c(2)</b>	.)	. 9e	
10	No	nexp	erience-rated contracts:					
	а	Tota	al premiums or subscription charges paid to ca	arrier			10a	2007594
	b	If the	e carrier, service, or other organization incurre	ed any specific costs in co	onnection wit	h the acquisition or		
			ntion of the contract or policy, other than repo				10b	

Pa	art IV	Provision of Information			
11	Did the i	insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
40					

12 If the answer to line 11 is "Yes," specify the information not provided.

Specify nature of costs.

SCHEDULE A		Insurance Information				OMB No. 1210-0110	
(Form 5500) Department of the Treasury		This schedule is required	d to be filed under sectio	on 104 of th	e		
Internal Revenue Service Employee Retirement In							2017
Department of Labo Employee Benefits Security Ad		File as an a	attachment to Form 55	00.			
Pension Benefit Guaranty Co	prporation	<ul> <li>Insurance companies a pursuant to E</li> </ul>	are required to provide t ERISA section 103(a)(2)		ion	This Fo	rm is Open to Public Inspection
· · ·	17 or fiscal plar	year beginning 07/01/2017		and en	ding 06/30	)/2018	•
A Name of plan KNIGHT PARTNERS LLC	CEMPLOYEE \	WELFARE BENEFIT PLAN			e-digit number (PN	)	501
C Plan sponsor's name a KNIGHT PARTNERS LLC		e 2a of Form 5500			oyer Identifica 1379618	ation Number	(EIN)
		ning Insurance Contract					
1 Coverage Information:							
(a) Name of insurance ca GUARDIAN LIFE INSURA		Y OF AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	contract year
(b) EIN	code	identification number	persons covered a policy or contrac	(T)		From	<b>(g)</b> To
13-5123390	64246	00478092	106				
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, b	prokers, and o	other persons in
(a) Total a	amount of comr			<b>(b)</b> To	otal amount c	of fees paid	
		8176					5082
3 Persons receiving com		ees. (Complete as many entries					
		nd address of the agent, broker,		m commiss	ions or fees	were paid	
ALLIANT INSURANCE SE	RVICES INC.		CLARK ST GO, IL 60654				
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose		(e) Organization code	
		5082					3
		nd address of the agent brains	or other person to when		iono or foo-	woro poid	
MESIROW INSURANCE S	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid           MESIROW INSURANCE SERVICES         353 N CLARK ST           CHICAGO, IL 60654         CHICAGO, IL 60654						
							1
(b) Amount of sales and base			es and other commission				4
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
	8176 3					3	
For Paperwork Reductio	n Act Notice, s	see the Instructions for Form 5	5500.			Sche	dule A (Form 5500) 2017 v. 170203

#### (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
			<u> </u>	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	<b>(c)</b> Amount	(d) Purpose	Organization code	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	

Schedule A (Form 5500) 2017

	Schedule A (Form 5500) 2017	Page <b>3</b>		
Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	vidual contracts with each carri	er may be treated as a unit f	or purposes of
<b>4</b> Cur	rent value of plan's interest under this contract in the general account at year	end		
<b>5</b> Cur	rent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Cor	tracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier			
С	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
	Specify nature of costs			
_				
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts	)	
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year			
С	Additions: (1) Contributions deposited during the year	7c(1)		
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)			
	$\mathbf{b}$			
	(6)Total additions			
Ь	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).			
_	Deductions:			
Ŭ	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(2) Administration charge made by carrier			
	(4) Other (specify below)			
	,			
			7.(5)	
4	(5) Total deductions			
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7</b> f	

Ρ	art I	III	Welfare Benefit Contract Informa				d	
			If more than one contract covers the same of the information may be combined for reporti employees, the entire group of such individu	ng purposes if such conti	racts are exp	erience-rated as a unit	. Where co	ontracts cover individual
8	Bon	ofit o	nd contract type (check all applicable boxes)		amer may be	treated as a unit for pt		nis report.
U	-	_			<b>م</b> ۲			
	a	_	ealth (other than dental or vision)	<b>b</b> X Dental	c	Vision		<b>d</b> Life insurance
	е	Те	emporary disability (accident and sickness)	f Long-term disabilit	y <b>g</b>	Supplemental unemp	oloyment	<b>h</b> Prescription drug
	i [	Ste	op loss (large deductible)	j 🗌 HMO contract	k	PPO contract		I Indemnity contract
	m	Ot	ther (specify)					
9	Expe	eriena	ce-rated contracts:					
			iums: (1) Amount received		9a(1)			-
		(2) Ir	ncrease (decrease) in amount due but unpaid		9a(2)			
		• •	ncrease (decrease) in unearned premium res		9a(3)			
		(4) E	Earned ((1) + (2) - (3))	······			9a(4)	
	b	Ben	efit charges (1) Claims paid		9b(1)			
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)			
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)	
		(4) C	Claims charged				9b(4)	
	С	Ren	nainder of premium: (1) Retention charges (or	n 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)		r	
			(H) Total retention	_	_		9c(1)(H)	
		(2) [	Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Stat	us of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)	
		(2) (	Claim reserves				9d(2)	
		(3) (	Other reserves				9d(3)	
	е	Divi	dends or retroactive rate refunds due. (Do no	t include amount entered	l in line <b>9c(2)</b>	.)	9e	
10	No	nexp	erience-rated contracts:					
	а	Tota	al premiums or subscription charges paid to ca	arrier			10a	81764
	b		e carrier, service, or other organization incurre					
		rete	ntion of the contract or policy, other than repo	rted in Part I, line 2 above	e, report amo	ount	10b	

Pa	art IV	Provision of Information			
11	Did the i	nsurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
40					

12 If the answer to line 11 is "Yes," specify the information not provided.

Specify nature of costs.

SCHEDULE (Form 5500		Insurar	nce Information	n		ОМ	1B No. 1210-0110	
Department of the Treas Internal Revenue Servi	sury		ed to be filed under section ncome Security Act of 19			2017		
Department of Labor Employee Benefits Security Ad	attachment to Form 55	00.						
Pension Benefit Guaranty Corporation Insurance companies are required to provide the pursuant to ERISA section 103(a)(2).							orm is Open to Public Inspection	
For calendar plan year 2017 or fiscal plan year beginning 07/01/2017				and en	nding 06/3	80/2018		
A Name of plan KNIGHT PARTNERS LLC	C EMPLOYEE V	VELFARE BENEFIT PLAN			e-digit number (Pl	N) 🕨	501	
C Plan sponsor's name as shown on line 2a of Form 5500 KNIGHT PARTNERS LLC					oyer Identific 1379618	ation Number (	(EIN)	
		ning Insurance Contrac Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance ca VISION SERVICE PLAN		1	(e) Approximate nu	umber of	I	Policy or co	ontract year	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year 116		(f) From		(g) To	
20-0891619	12516	12123774			07/01/201	7	06/30/2018	
2 Insurance fee and com descending order of the		tion. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in	
<b>(a)</b> Total a	amount of comn	nissions paid		<b>(b)</b> To	otal amount	of fees paid		
		1211						
3 Persons receiving com	missions and fe	es. (Complete as many entries	s as needed to report all	persons).				
		nd address of the agent, broker			ions or fees	were paid		
MESIROW INSURANCE S	SERVICES, INC	. 6312 : GREE	S FDL FN CIR STE 550E NWOOD VILLAGE, CO	<u>=</u> 80111-506	6			
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid				
commissions paid		(c) Amount		(d) Purpos	е		(e) Organization code	
	1211						3	
	(a) Name ar	nd address of the agent, broker	r, or other person to who	m commiss	ions or fees	were paid		
							1	

(b) Amount of sales and base	Fe		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	dule A (Form 5500) 2017		

Schedule A (Form 5500) 2017 v. 170203

#### (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
			<u> </u>	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	<b>(c)</b> Amount	(d) Purpose	Organization code	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	

Schedule A (Form 5500) 2017

	Schedule A (Form 5500) 2017	Page <b>3</b>		
Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	vidual contracts with each carri	er may be treated as a unit f	or purposes of
<b>4</b> Cur	rent value of plan's interest under this contract in the general account at year	end		
<b>5</b> Cur	rent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Cor	tracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier			
С	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
	Specify nature of costs			
_				
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts	)	
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year			
С	Additions: (1) Contributions deposited during the year	7c(1)	<b>I</b>	
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)			
	$\mathbf{b}$			
	(6)Total additions			
Ь	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).			
_	Deductions:			
Ŭ	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(2) Administration charge made by carrier			
	(4) Other (specify below)			
	,			
			7.(5)	
4	(5) Total deductions			
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7</b> f	

	art I	If more than one contract covers the same of the information may be combined for report employees, the entire group of such individu	group of employees of the ing purposes if such contra	acts are expe	erience-rated as a unit	Where co	ontracts cover individual
8	Bene	efit and contract type (check all applicable boxes)					
	a	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 disability	g	Supplemental unemp	oloyment	h Prescription drug
	i	Stop loss (large deductible)	j 🗌 HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)			-		
9	Expe	erience-rated contracts:	_				
	a F	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	l	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	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)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n 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)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in o	cash, or	credited.)	9c(2)	
	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				9e	
10		nexperience-rated contracts:			,		
-		Total premiums or subscription charges paid to c	arrier			10a	23631
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	
		teres and contract of policy, caller than tope		,	•••••		

Pa	art IV Provision of Information			
11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
40				

12 If the answer to line 11 is "Yes," specify the information not provided.

Specify nature of costs.

SCHEDULE		Insurance Information				OMB No. 1210-0110	
(Form 5500 Department of the Treas Internal Revenue Serv	sury	- This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					
Department of Labor Employee Benefits Security Administration			attachment to Form 55	00.			
Pension Benefit Guaranty Corporation Insurance companies			are required to provide t ERISA section 103(a)(2)		tion		m is Open to Public Inspection
For calendar plan year 20	17 or fiscal plan	year beginning 07/01/2017		and er	nding 06/3	30/2018	
A Name of plan KNIGHT PARTNERS LLC	C EMPLOYEE V	VELFARE BENEFIT PLAN			e-digit number (P	N) 🕨	501
C Plan sponsor's name a KNIGHT PARTNERS LLC		2a of Form 5500			oyer Identific 1379618	cation Number (	(EIN)
Part I Information a separation	tion Concern ate Schedule A.	ning Insurance Contrac	t Coverage, Fees, as a unit in Parts II and II	and Cor I can be re	nmission ported on a	IS Provide infor single Schedul	mation for each contract e A.
<b>1</b> Coverage Information:							
(a) Name of insurance ca UNUM INSURACE COMP		ICA					
(c) NAIC		(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
01-0278678	62235	00000204625	131	131		7	06/30/2018
2 Insurance fee and com descending order of the		tion. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comn	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
		6141					
3 Persons receiving com	missions and fe	es. (Complete as many entries	s as needed to report all	persons).			
		nd address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
MESIROW INSURANCE S	SERVICES, INC		CLARK ST AGO, IL 60654				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			-
commissions pa		(c) Amount		(d) Purpos			(e) Organization code
5172 969			ADDITIONAL COMPENSATION PAID				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 color or	nd base	Fe	es and other commission	ns paid			
(b) Amount of sales and base commissions paid		(c) Amount		(d) Purpose			(e) Organization code

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

#### (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

	Fees and other commissions paid		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
			<u> </u>

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

	Fees and other commissions paid		
(b) Amount of sales and base commissions paid	<b>(c)</b> Amount	(d) Purpose	Organization code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

Schedule A (Form 5500) 2017

	Schedule A (Form 5500) 2017	Page <b>3</b>		
Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	vidual contracts with each carri	er may be treated as a unit f	or purposes of
<b>4</b> Cur	rent value of plan's interest under this contract in the general account at year	end		
<b>5</b> Cur	rent value of plan's interest under this contract in separate accounts at year e	end		
6 Cor	tracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier			
С	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
	Specify nature of costs			
_				
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts	)	
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year			
С	Additions: (1) Contributions deposited during the year	7c(1)		
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)			
	$\mathbf{b}$			
	(6)Total additions			
Ь	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).			
_	Deductions:			
Ŭ	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(2) Administration charge made by carrier			
	(4) Other (specify below)			
	,			
			7.(5)	
4	(5) Total deductions			
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7</b> f	

Ρ	art		Welfare Benefit Contract Informa						
			If more than one contract covers the same g the information may be combined for reporti						
			employees, the entire group of such individu						
8	Ben	efit a	nd contract type (check all applicable boxes)						
	а	He	ealth (other than dental or vision)	<b>b</b> Dental	c	Vision		<b>d</b> X Life insurance	
	e	K Te	emporary disability (accident and sickness)	f X Long-term disabilit	ty g	Supplemental unemp	oloyment	h Prescription drug	J
	ίĪ	Ste	op loss (large deductible)	j 🗍 HMO contract	k [	PPO contract		I Indemnity contra	ct
	m	_	ther (specify)	-	L	1			
	L								
9	Expe	eriend	ce-rated contracts:						
			iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid		9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	Earned ( <b>(1) + (2) - (3)</b> )				9a(4)		
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
			ncurred claims (add (1) and (2))				9b(3)		
			Claims charged				9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (or	n 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)				
			(H) Total retention				9c(1)(H)		
		(2) [	Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Stat	us of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)		
			Claim reserves	•			9d(2)		
		(3) (	Other reserves				9d(3)		
	е	• •	dends or retroactive rate refunds due. (Do no				9e		
10	) No		erience-rated contracts:			,			
		•	al premiums or subscription charges paid to ca	arrier			10a		52369
	b	If the	e carrier, service, or other organization incurre	ed any specific costs in c	onnection wit	h the acquisition or			
			ntion of the contract or policy, other than repo				10b		

Pa	art IV Provision of Information			
11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
40				

12 If the answer to line 11 is "Yes," specify the information not provided.

Specify nature of costs.

A Name of plan       Structure	SCHEDULE C	Service Provider I	nformation		OMB No. 1210-0110	
Employee Breidtie Security Administration       P File as an attachment to Form 5500.       This Form is Open to Public Inspection.         For calendar plan year 2017 or fiscal plan year beginning       07/01/2017       and ending       06/30/2018         A Name of plan       B Three-digit       plan number (PN)       501         C Plan sponsor's name as shown on line 2a of Form 5500       D Employer Identification Number (EIN)       501         C Plan sponsor's name as shown on line 2a of Form 5500       D Employer Identification Number (EIN)       37-1379618         Part I Service Provider Information (see instructions)         You must complete this Part, in accordance with the instructions, to report the information required for each person who received, directly or indirectly, \$5,00         or more in total compensation (i.e., money or anything dise of monetary value) in connection with services rendered to the plan or the person's position with plan during the plan year. If a person received only eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person whon completing the remainder of this Part because they received only eligible indirect compensation for which the plan received the required bisclosures (see instructions).         1       Information on Persons Receiving Only Eligible Indirect Compensation         2       Information for which the plan received the required disclosures for the service providers who received only eligible indirect compensation.         1	Department of the Treasury			2017		
For calendar plan year 2017 or fiscal plan year beginning       07/01/2017       and ending       06/30/2018         A Name of plan       B       Three-digit       501         KNIGHT PARTNERS LLC EMPLOYEE WELFARE BENEFIT PLAN       B       Three-digit       501         C Plan sponsor's name as shown on line 2a of Form 5500       D       Employer Identification Number (EIN)       37-1379618         Part I       Service Provider Information (see instructions)       O       Employer Identification Number (EIN)         You must complete this Part, in accordance with the instructions, to report the information required for each person who received, directly or indirectly, \$5,00         You must complete this Part, in accordance with the instructions to report the information required for each person who received, directly or indirectly, \$5,00         You must complete this Part, in accordance with the instructions to report the information required to the plan or the person's position with 1 plan during the plan year. If a person received only eligible indirect compensation for which the plan received only eligible indirect or previses rendered to the plan or the guired to include that person when completing the remainder of this Part.         1 Information on Persons Receiving Only Eligible Indirect Compensation       Complexes of Pars or the indirect workers who received only eligible indirect compensation for which the plan received the required disclosures (see instructions).       I wear who received only eligible indirect compensation         b If you answered line 1a "Yes," enter the name and EIN o	Employee Benefits Security Administration	File as an attachment				
A Name of plan KNIGHT PARTNERS LLC EMPLOYEE WELFARE BENEFIT PLAN       B Three-digit plan number (PN)       501         C Plan sponsor's name as shown on line 2a of Form 5500 KNIGHT PARTNERS LLC       D Employer Identification Number (EIN) 37-1379618         Part I Service Provider Information (see instructions, to report the information required for each person who received, directly or indirectly, \$5,00 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with plan during the plan year. (I a person received only eligible indirect ompensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.         1 Information on Persons Receiving Only Eligible Indirect Compensation answer line 1 but are not required to include the required disclosures (see instructions for definitions and conditions)		n year beginning 07/01/2017	and ending 06/3	0/2018	-	
KNIGHT PARTNERS LLC       37-1379618         Part I       Service Provider Information (see instructions)         You must complete this Part, in accordance with the instructions, to report the information required for each person who received, directly or indirectly, \$5,00 are required to induce that person who received the plan or the person's position with answer line 1 but are not required to include that person who completing the remainder of this Part.         1       Information on Persons Receiving Only Eligible Indirect Compensation for which the plan received only eligible indirect compensation for which the plan received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)	•		B Three-digit	•	501	
You must complete this Part, in accordance with the instructions, to report the information required for <b>each person</b> who received, directly or indirectly, \$5,00 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with plan during the plan year. If a person received <b>only</b> eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.  1 Information on Persons Receiving Only Eligible Indirect Compensation a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions) [Yes ⊠ No b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).  (b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation (b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation (b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation		ne 2a of Form 5500		on Number	(EIN)	
You must complete this Part, in accordance with the instructions, to report the information required for <b>each person</b> who received, directly or indirectly, \$5,00 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with plan during the plan year. If a person received <b>only</b> eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.  1 Information on Persons Receiving Only Eligible Indirect Compensation a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions) [Yes ⊠ No b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).  (b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation (b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation (b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	Part I Service Provider Info	ormation (see instructions)				
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	<ul><li>a Check "Yes" or "No" to indicate wheth indirect compensation for which the p</li><li>b If you answered line 1a "Yes," enter</li></ul>	her you are excluding a person from the remain lan received the required disclosures (see inst the name and EIN or address of each person	nder of this Part because they recei tructions for definitions and condition providing the required disclosures f	ns)	Yes XNo	
	(b) Enter nar	me and EIN or address of person who provide	d you disclosures on eligible indirec	t compensa	ation	
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	(b) Enter nar	me and EIN or address of person who provide	d you disclosures on eligible indirec	t compensa	ation	
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation						
	(b) Enter nar	me and EIN or address of person who provide	d vou disclosures on eliaible indirec	t compense	ation	
				r oompense		

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

Page 2- 1

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

# 2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

<b>(b)</b> Service	(c) Relationship to	(d) Enter direct	(e) Did service provider	(f) Did indirect compensation	(g) Enter total indirect	<b>(h)</b> Did the service				
Code(s)	employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	receive indirect compensation? (sources other than plan or plan sponsor)	include eligible indirect compensation, for which the plan received the required disclosures?	compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?				
Yes         No         Yes         No         Yes         No										
	(a) Enter name and EIN or address (see instructions)									

<b>(b)</b> Service Code(s)	(C) 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		(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0				
	Yes         No         Yes         No         Yes         No								
	(a) Enter name and EIN or address (see instructions)								

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	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	Did the service provider give you a formula instead of an amount or
					answered "Yes" to element (f). If none, enter -0	
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗍

# 2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

<b>(b)</b> Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(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?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0				
			Yes No	Yes No		Yes No			
	(a) Enter name and EIN or address (see instructions)								

<b>(b)</b> Service Code(s)	(C) 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		(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0		
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗍	
	(a) Enter name and EIN or address (see instructions)						

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service	Relationship to	Enter direct	Did service provider	Did indirect compensation	Enter total indirect	Did the service
Code(s)	employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	receive indirect compensation? (sources other than plan or plan sponsor)	include eligible indirect compensation, for which the plan received the required disclosures?	compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗍

Part I Service Provider Information (continued)		
3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation or provides contract administrator, consulting, custodial, investment advisory, investment mana questions for (a) each source from whom the service provider received \$1,000 or more in indire 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.	gement, broker, or recordkeepin ct compensation and (b) each s	g services, answer the following ource for whom the service
(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 e 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 e 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 e the service provider's eligibility the indirect compensation.

Page **5 -** 1

Pa	rt II Service Providers Who Fail or Refuse to I	Provide Infori	mation			
4	4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.					
	(a) Enter name and EIN 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			
	<b>a)</b> Enter name and EIN or address of service provider (see	(b) Nature of	(C) Describe the information that the service provider failed or refused to			
	instructions)	Service Code(s)	provide			
	( <b>a)</b> Enter name and EIN 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			
	<b>a)</b> Enter name and EIN 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			
	<b>(a)</b> Enter name and EIN 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			
(	<b>(a)</b> Enter name and EIN 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			

Page 6 - 1

e Telephone:

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)			
a Name:	b EIN:		
C Position:			
d Address:	e Telephone:		
Explanation:			
a Name:	<b>b</b> EIN:		
C Position:			

Explanation:

Name:	<b>b</b> EIN:
Position:	
Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	<b>e</b> Telephone:

Explanation: