Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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

2018

This Form is Open to Public Inspection

				inspection		
Part I	Annual Report Ide	ntification Information				
For calend	ar plan year 2018 or fiscal	plan year beginning 01/01/2018	and ending 12/31/20	18		
A This ret	urn/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking the participating employer information in accordance)			
		X a single-employer plan	a DFE (specify)			
B This ret	urn/report is:	the first return/report	the final return/report			
		an amended return/report	a short plan year return/report (less than 12	2 months)		
C If the pl	an is a collectively-bargair	ned plan, check here				
D Check b	oox if filing under:	Form 5558	automatic extension	the DFVC program		
		special extension (enter description	n)			
Part II	Basic Plan Inform	ation—enter all requested information	on			
1a Name CHILDRE	•	CE FLEXIBLE BENEFITS PLAN		1b Three-digit plan number (PN) ▶ 501		
				1c Effective date of plan 11/01/1992		
Mailing City or	g address (include room, a town, state or province, c	if for a single-employer plan) apt., suite no. and street, or P.O. Box) ountry, and ZIP or foreign postal code		2b Employer Identification Number (EIN) 05-0258819		
CHILDRENS FRIEND AND SERVICE 2c Plan Sponsor's telep number 401-276-4300						
153 SUMM PROVIDEN	ER ST ICE, RI 02903-4011	153 SUMM PROVIDE	MER ST NCE, RI 02903-4011	2d Business code (see instructions) 624100		
Caution: A	A penalty for the late or i	ncomplete filing of this return/repo	rt will be assessed unless reasonable cause is	s 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. Signature of plan administrator	05/29/2019 Date	DAVID CAPRIO Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature. Signature of employer/plan sponsor	05/29/2019 Date	DAVID CAPRIO Enter name of individual signing as employer or plan sponsor
SIGN 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 (2018) v. 171027

Page 2 Form 5500 (2018) **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN **3c** Administrator's telephone number 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, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: 4d PN Sponsor's name Plan Name Total number of participants at the beginning of the plan year 406 5 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 406 a(1) Total number of active participants at the beginning of the plan year 6a(1)398 a(2) Total number of active participants at the end of the plan year 6a(2)Retired or separated participants receiving benefits..... 6b Other retired or separated participants entitled to future benefits...... 6c 398 6d Subtotal. Add lines 6a(2), 6b, and 6c..... Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e 398 Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item) Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)...... 7 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: 4B 4D 4H 4Q Plan funding arrangement (check all that apply) 9h Plan benefit arrangement (check all that apply)

(1) Insurance (1) 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 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules **b** General Schedules R (Retirement Plan Information) (1) (1) H (Financial Information) (2) I (Financial Information – Small Plan) MB (Multiemployer Defined Benefit Plan and Certain Money (2) X (3) 6 A (Insurance Information) Purchase Plan Actuarial Information) - signed by the plan actuary (4) **C** (Service Provider Information) **D** (DFE/Participating Plan Information) (5) (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary **G** (Financial Transaction Schedules) (6)

Form 5500 (2018)

Page 3

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)
11c Enter the Receipt Confirmation Code for the 2018 Form M-1 annual report. If the plan was not required to file the 2018 Form M-1 annual report, enter the Receipt 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 Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) Receipt Confirmation Code

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

2018

This Form is Open to Public

pursuant to ERISA section 103(a)(2).							Inspection	
For calendar plan year 20	18 or fiscal plan	year beginning 01/01/2018		and en	ding 12/3	1/2018		
A Name of plan CHILDRENS FRIEND AN	LEXIBLE BENEFITS PLAN		B Three	e-digit number (PI	N) •	501		
C Plan sponsor's name a CHILDRENS FRIEND AN		e 2a of Form 5500			yer Identific 0258819	ation Number (EIN)	
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca UNUM LIFE INSURANCE		AMERICA						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To	
01-0278678	62235	395971	22		01/01/2018	8	01/01/2019	
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tota	l commissions paid. Li	st in line 3	the agents,	brokers, and of	her persons in	
(a) Total a	amount of comn	nissions paid 1139		(b) To	otal amount	of fees paid		
		1139						
3 Persons receiving com		ees. (Complete as many entries a						
DDOV/IDED INCLIDANCE		nd address of the agent, broker, o		n commiss	ions or fees	were paid		
PROVIDER INSURANCE	GROUP, LLC	PO BOX BANGO	R, ME 04402					
(b) Amount of sales ar	nd base	Fees	and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code	
	1139						3	
	(a) Name a	nd address of the agent, broker, o	or other person to whon	n commiss	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fees	and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code	

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a ur								
		this report.								
		ent value of plan's interest under this contract in the general account at year			4					
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5					
6		racts 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 co			6d					
		retention of the contract or policy, enter amount.			-					
		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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)						
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee						
		(3) ☐ guaranteed investment (4) ☐ other ▶								
		-								
	b	Balance at the end of the previous year			7b					
	С	Additions: (1) Contributions deposited during the year								
		(2) Dividends and credits	7c(2)							
		(3) Interest credited during the year	. 7c(3)							
		(4) Transferred from separate account	7c(4)							
		(5) Other (specify below)	. 7c(5)							
		•								
	_	(6)Total additions			7c(6)					
		Total of balance and additions (add lines 7b and 7c(6))			7d					
		Deductions:	7-(4)							
		(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) 7e(4)							
		(4) Other (specify below)	. /e(4)							
		•								
		(5) Total deductions			7e(5)					
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f					

P	art I	III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual.	group ting pu	of em	s if such	contra	acts are	expe	erience-rated as a unit	. Where	contrac	ts cover individual),
8	Ben	efit a	nd contract type (check all applicable boxes)											
	а	Не	ealth (other than dental or vision)	b	Dent	tal			с	Vision		d	Life insurance	
	е	Te	emporary disability (accident and sickness)	f∏	Long	g-term dis	ability	У	g∏	Supplemental unemp	loyment	h \square	Prescription drug	
	ιĖ	_	op loss (large deductible)	iΠ		ontract			~ 느	PPO contract	•	ıĦ	Indemnity contract	t
	m	_	her (specify) LIFESTYLE LIFE	, _□		Communic			-`∟	111000111111111		- □	macrimity contract	•
		<u> </u>	iner (specify) FEITESTTEE EITE											
9	Fxpe	erien	ce-rated contracts:											
			iums: (1) Amount received				Г	9a(1))					
			ncrease (decrease) in amount due but unpaid				-	9a(2)						
			ncrease (decrease) in unearned premium res					9a(3))					
		(4) E	Earned ((1) + (2) - (3))				<u>-</u>				9a(4))		
	b	Ben	efit charges (1) Claims paid					9b(1))					
		(2) lı	ncrease (decrease) in claim reserves					9b(2))					
		(3) lı	ncurred claims (add (1) and (2))								9b(3)		
		(4) (Claims charged								9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	n an a	accrua	ıl basis)	-							
			(A) Commissions				-	9c(1)(/						
			(B) Administrative service or other fees					9c(1)(l						
			(C) Other specific acquisition costs				F	9c(1)(0						
			(D) Other expenses					9c(1)(I	-					
			(E) Taxes				F	9c(1)(l						
			(F) Charges for risks or other contingencies (G) Other retention charges				F	9c(1)(
			(H) Total retention(H)				<u>L</u>				9c(1)(H)		
			Dividends or retroactive rate refunds. (These			_			_					
	d		us of policyholder reserves at end of year: (1								9c(2) 9d(1)			
	u		Claim reserves								9d(2			
		` '	Other reserves								9d(3			
	е	` '	dends or retroactive rate refunds due. (Do n								9e			
10			erience-rated contracts:						- (- /-	,				
			al premiums or subscription charges paid to d	carrier.							10a			7592
	b Spe	rete	e carrier, service, or other organization incurintion of the contract or policy, other than repeature of costs.								10b			
D	art l	NV.	Provision of Information											
	art I									🗆	.,			
			insurance company fail to provide any inform				omple	ete Sche	dule	A?	Yes	X N	lo	
12	! If th	he ar	nswer to line 11 is "Yes," specify the informat	ion not	t provi	ided. 🕨								

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

			RISA section 103(a)(2).	Inis Fo	rm is Open to Public Inspection
For calendar plan year 20	18 or fiscal plar	year beginning 01/01/2018	and e	nding 12/31/2018	
A Name of plan CHILDRENS FRIEND AN	ID SERVICE FL	LEXIBLE BENEFITS PLAN		ee-digit n number (PN)	501
C Plan sponsor's name a CHILDRENS FRIEND AN		e 2a of Form 5500		loyer Identification Number 5-0258819	(EIN)
		ning Insurance Contract . Individual contracts grouped as			
1 Coverage Information:					
(a) Name of insurance ca					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	Policy or o	contract year
(b) LIN	code	identification number	policy or contract year	(f) From	(g) To
05-0296998	55301	4160_1	603	01/01/2018	12/31/2018
2 Insurance fee and come descending order of the		ation. Enter the total fees and tota	I commissions paid. List in line 3	3 the agents, brokers, and o	other persons in
(a) Total a	amount of comm		(b) T	otal amount of fees paid	
		5591			
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, o	or other person to whom commis	sions or fees were paid	
CROSS INSURANCE DBA	PROVIDERS		(1388 R, ME 04402		
(b) Amount of sales ar	nd base	Fees	and other commissions paid		
commissions pai		(c) Amount	(d) Purpos	se	(e) Organization code
	966				3
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	sions or fees were paid	
PROVIDER INSURANCE (160 GO	ULD ST., STE 130 AM, MA 02494		
(b) Amount of sales ar	nd hase	Fees	s and other commissions paid		
commissions pai		(c) Amount	(d) Purpos	(e) Organization code	
	4625				3
For Panerwork Reduction	n Act Notice s	see the Instructions for Form 5	500	Sche	

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a ur								
		this report.								
		ent value of plan's interest under this contract in the general account at year			4					
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5					
6		racts 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 co			6d					
		retention of the contract or policy, enter amount.			-					
		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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)						
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee						
		(3) ☐ guaranteed investment (4) ☐ other ▶								
		-								
	b	Balance at the end of the previous year			7b					
	С	Additions: (1) Contributions deposited during the year								
		(2) Dividends and credits	7c(2)							
		(3) Interest credited during the year	. 7c(3)							
		(4) Transferred from separate account	7c(4)							
		(5) Other (specify below)	. 7c(5)							
		•								
	_	(6)Total additions			7c(6)					
		Total of balance and additions (add lines 7b and 7c(6))			7d					
		Deductions:	7-(4)							
		(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) 7e(4)							
		(4) Other (specify below)	. /e(4)							
		•								
		(5) Total deductions			7e(5)					
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f					

Pa	art	III Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same g					
		the information may be combined for reportir employees, the entire group of such individual					
Ω	Bon	nefit and contract type (check all applicable boxes)	ar doritradio with cach of	amer may be	troated as a drift for p	uiposos oi t	по горога
•	Г	—	b X Dental	۔ ۔	Vision		d ☐ Life insurance
	a [_	<u> </u>			<u> </u>
	е	Temporary disability (accident and sickness)	f Long-term disabilit	· - <u>-</u>	Supplemental unem	ployment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Expe	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 rese					
		(4) Earned ((1) + (2) - (3))				. 9a(4)	
	b	Benefit charges (1) Claims paid		` '			
		(2) Increase (decrease) in claim reserves		. , ,		01 (0)	
		(3) Incurred claims (add (1) and (2))				. 9b(3)	
	_	(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (on	•	00/1)/(1)			
		(A) Commissions(B) Administrative service or other fees		9c(1)(A) 9c(1)(B)			
		(C) Other specific acquisition costs		0 (4)(0)			
		(D) Other expenses		0 (4)(D)			
		(E) Taxes					
		(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 a	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	_	_			
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves				. 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	d in line 9c(2) .	.)	. 9e	
10	No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			. 10a	209793
	b	If the carrier, service, or other organization incurre	, ,		•		
	Cna	retention of the contract or policy, other than repor	ted in Part I, line 2 abov	e, report amo	unt	10b	
	Spe	ecify nature of costs.					
P	art	IV Provision of Information					
			tion nooceans to corre	oto Sahadul-	л2 П	Yes	No No
		id the insurance company fail to provide any informa		ere ocueanie	A!	169	V 140
12	If t	the answer to line 11 is "Yes," specify the information	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2018

This Form is Open to Public

		pursuant to EF	RISA section 103(a)(2).		111101011	Inspection
For calendar plan year 20	18 or fiscal plar	year beginning 01/01/2018	an	d ending 12/	31/2018	
A Name of plan CHILDRENS FRIEND AN	ID SERVICE FL	EXIBLE BENEFITS PLAN		Three-digit plan number (P	PN)	501
C Plan sponsor's name a CHILDRENS FRIEND AN		e 2a of Form 5500	D E	mployer Identifi 05-0258819	cation Number (EIN)
		ning Insurance Contract Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca						
a > ===	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	of (f)) From	(g) To
05-0296998	55301	4160_2	2	01/01/201	18	12/31/2018
2 Insurance fee and composite descending order of the		ation. Enter the total fees and total	commissions paid. List in li	ne 3 the agents	, brokers, and o	ther persons in
(a) Total a	amount of comr		(b) Total amount	t of fees paid	
		18				
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all persor	ns).		
		nd address of the agent, broker, o		missions or fee	s were paid	
CROSS INSURANCE DBA	PROVIDER IN		.1388 R, ME 04402			
(b) Amount of sales ar	nd base	Fees	and other commissions paid	<u> </u>		
commissions pai		(c) Amount	(d) Pu	rpose		(e) Organization code
	3					3
	(a) Name a	nd address of the agent, broker, o	or other person to whom com	missions or fee:	s were paid	
PROVIDER INSURANCE		160 GOL	JLD ST., STE 130 AM, MA 02494		,	
(b) Amount of sales ar	nd base	Fees	and other commissions paid	l		
commissions pai		(c) Amount	(d) Purpose			(e) Organization code
	15					3

Schedule A (Form 5500) 2018 Page 2 - 1					
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
		From and other constitutions and	(-)		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	T		(e)		
(b) Amount of sales and base		Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
, ,	<u> </u>				
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
•					
(a) Na	The standard of the stand business				
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization		
commissions paid	(0)	(a) supers	code		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	T		1		
(h) Amount of sales and hase		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code		
			Organization		

Part II		II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	vith each carrier may be	e treated a	as a unit for purposes of	
		this report.				
		ent value of plan's interest under this contract in the general account at year			4	
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts 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 co			6d	
		retention of the contract or policy, enter amount.			-	
		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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		-				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:	7-(4)			
		(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) 7e(4)			
		(4) Other (specify below)	. /e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Ρ	art III							
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ing purposes if such cont	racts are expe	erience-rated as a unit.	Where cor	ntracts o	cover individual
8	Benefi	t and contract type (check all applicable boxes)						
	а ∏	Health (other than dental or vision)	b X Dental	С	Vision	(d∏ Lif	fe insurance
	е 🗍	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemplo	vment	h ☐ Pr	rescription drug
	; H	Stop loss (large deductible)	j HMO contract		PPO contract	,		demnity contract
	'		I I I I I I I I I I I I I I I I I I I	κ	FFO COILLACT		· 🗆 ""	definity contract
	m _	Other (specify)						
_	F	and a sector of a sector of a						
9	•	ence-rated contracts:		00(1)			-	
		emiums: (1) Amount received		```		-	-	
	,	 Increase (decrease) in amount due but unpaid Increase (decrease) in unearned premium res 					-	
		l) Earned ((1) + (2) - (3))				9a(4)		
	_ `	Benefit charges (1) Claims paid				<u> </u>		
		2) Increase (decrease) in claim reserves		(-)			-	
	,	B) Incurred claims (add (1) and (2))				9b(3)		
	•	l) Claims charged				9b(4)	1	
	,	Remainder of premium: (1) Retention charges (c						
		(A) Commissions		9c(1)(A)			1	
		(B) Administrative service or other fees		2 (1)(7)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses						
		(E) Taxes						
		(F) Charges for risks or other contingencies						
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention	_	_		9c(1)(H)	<u> </u>	
	(2	Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	credited.)	9c(2)		
	d s	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)		
	(2	2) Claim reserves				9d(2)		
	,	3) Other reserves				9d(3)		
40		Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2) .	.)	9e		
10		experience-rated contracts:				40.		
	_	otal premiums or subscription charges paid to c				10a	+	671
	re	the carrier, service, or other organization incurrectention of the contract or policy, other than representative of costs.	, .		•	10b		
	art IV				🗇			
		he insurance company fail to provide any inform		lete Schedule	A? Y	es >	X No	
12	If the	answer to line 11 is "Yes," specify the informat	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant to EF	RISA section 103(a)(2).				Inspection
For calendar plan year 20	18 or fiscal plan	year beginning 01/01/2018		and en	ding 12/3	1/2018	
A Name of plan CHILDRENS FRIEND AN	ID SERVICE FL	EXIBLE BENEFITS PLAN		B Three plan	e-digit number (PI	N) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 CHILDRENS FRIEND AND SERVICE D Employer Identification Number (I					EIN)		
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		MPANY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate num persons covered at e				ontract year
(-,	code	identification number	policy or contract y		(f)	From	(g) To
36-2739571	79413	753421	583		01/01/2018	8	12/31/2018
2 Insurance fee and com- descending order of the		tion. Enter the total fees and total	I commissions paid. List				her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid 40471							
		40471					
3 Persons receiving com		es. (Complete as many entries a					
PROVIDER INSURANCE			or other person to whom ULD ST STE 130 AM, MA 02494	commissi	ions or fees	were paid	
(b) Amount of color or	4 5 5 5	Fees	and other commissions	s paid			
(b) Amount of sales ar commissions pa		(c) Amount		l) Purpose	e		(e) Organization code
	40471						3
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commissi	ions or fees	were paid	
	.,	-	·			·	
(b) Amount of sales ar	nd base	Fees	and other commissions	paid			
commissions pa		(c) Amount	(d	l) Purpose	9		(e) Organization code
	- A-(N-(i	and the leastwestians for Forms 55				Oakaa	iulo A (Form FF00) 2049

Schedule A (Form 5500) 2018 Page 2 - 1					
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
		From and other constitutions and	(-)		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	T		(e)		
(b) Amount of sales and base		Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
, ,	<u> </u>				
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
•					
(a) Na	The standard of the stand business				
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization		
commissions paid	(0)	(a) supers	code		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	T		1		
(h) Amount of sales and hase		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code		
			Organization		

Part II		II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	vith each carrier may be	e treated a	as a unit for purposes of	
		this report.				
		ent value of plan's interest under this contract in the general account at year			4	
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts 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 co			6d	
		retention of the contract or policy, enter amount.			-	
		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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		-				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:	7-(4)			
		(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) 7e(4)			
		(4) Other (specify below)	. /e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

P	art	Ш	Welfare Benefit Contract Informal If more than one contract covers the same		s same emplo	over(s) or members of t	the same or	mplovee organizatio	ne(e)
			the information may be combined for repor employees, the entire group of such individ	ing purposes if such conti	racts are expe	érience-rated as a unit	. Where co	ontracts cover individ	` ' '
8	Ben	efit a	nd contract type (check all applicable boxes)						
	а	X He	ealth (other than dental or vision)	b Dental	С	Vision		d Life insurance)
	е	Te	emporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemp	oloyment	h Prescription of	rug
	i į		op loss (large deductible)	j HMO contract	, <u> </u>	PPO contract	,	I Indemnity cor	-
	m		ther (specify)	- Ц	<u> </u>	1			
								_	
9	Exp	erien	ce-rated contracts:						
	a		iums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpai						
			ncrease (decrease) in unearned premium res	· ·					
			Earned ((1) + (2) - (3))				9a(4)		
	b		efit charges (1) Claims paid						
		. ,	ncrease (decrease) in claim reserves				01 (0)		
			ncurred claims (add (1) and (2))				9b(3)		
	_	. ,	Claims charged				9b(4)		
	С		nainder of premium: (1) Retention charges (c	, i	00/41/41				
			(A) Commissions		9c(1)(A) 9c(1)(B)				
			(B) Administrative service or other fees		9c(1)(C)				
			(C) Other specific acquisition costs(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						
			(H) Total retention	· ·	l l		9c(1)(H)		
			Dividends or retroactive rate refunds. (These	_	_		9c(2)		
	d		us of policyholder reserves at end of year: (1	_			9d(1)		
	~		Claim reserves				9d(2)		
		. ,	Other reserves				9d(3)		
	е	` '	dends or retroactive rate refunds due. (Do n				9e		
10	No		erience-rated contracts:		,	,			
	а		al premiums or subscription charges paid to	arrier			10a		405272
	b		e carrier, service, or other organization incur						
		rete	ntion of the contract or policy, other than rep nature of costs.				10b		
	Spe	ecity r	nature of costs.						
Pa	art	IV	Provision of Information						
11	Die	d the	insurance company fail to provide any inform	nation necessary to compl	ete Schedule	A?	Yes	X No	
			nswer to line 11 is "Yes," specify the informat			· <u> </u>			

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

		pursuant to EF	RISA section 103(a)(2).				Inspection
For calendar plan year 20	18 or fiscal plan	year beginning 01/01/2018		and en	ding 12/3	1/2018	
A Name of plan CHILDRENS FRIEND AN	ID SERVICE FL	EXIBLE BENEFITS PLAN			e-digit number (PI	N) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 CHILDRENS FRIEND AND SERVICE D Employer Identification Number (IDENTITY OF THE PROPERTY OF THE PROPERT					EIN)		
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca UNUM LIFE INSURANCE		AMERICA					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nur persons covered at				ontract year I
(5) 2	code	identification number	policy or contract		(f)	From	(g) To
01-0278678	62235	395970	394		01/01/2018	8	01/01/2019
2 Insurance fee and come descending order of the		tion. Enter the total fees and total	commissions paid. Lis	t in line 3	the agents,	brokers, and of	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		01/3					
3 Persons receiving com		es. (Complete as many entries a					
PROVIDER INSURANCE (nd address of the agent, broker, or PO BOX	•	commiss	ions or fees	were paid	
PROVIDER INSURANCE V	GROOF, LLC		R, ME 04402				
(b) Amount of sales ar	nd base	Fees	and other commissions	s paid			
commissions pai	id	(c) Amount	(0	(d) Purpose			(e) Organization code
	6173						3
	(a) Name a	nd address of the agent, broker, c	or other person to whom	commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fees	and other commissions	s paid			
commissions pai	id	(c) Amount	(0	d) Purpose	9		(e) Organization code
Ess Barrers de Barbardia	n Ant Nation	see the Instructions for Form 55	200			0-1	hulo A (Form FF00) 2019

Schedule A (Form 5500) 2018 Page 2 - 1					
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
		From and other constitutions and	(-)		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	T		(e)		
(b) Amount of sales and base		Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
, ,	<u> </u>				
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
•					
(a) Na	The standard of the stand business				
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization		
commissions paid	(0)	(a) supers	code		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	T		1		
(h) Amount of sales and hase		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code		
			Organization		

Part II		II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	vith each carrier may be	e treated a	as a unit for purposes of	
		this report.				
		ent value of plan's interest under this contract in the general account at year			4	
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts 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 co			6d	
		retention of the contract or policy, enter amount.			-	
		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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		-				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:	7-(4)			
		(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) 7e(4)			
		(4) Other (specify below)	. /e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

sion) b Dental c Vision d Main Life insurance t and sickness) f Long-term disability g Supplemental unemployment h Prescription drug j HMO contract k PPO contract 9a(1)	P	art I	III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such c employees, the entire group of such individual contracts with eacl	ontracts are expe	erience-rated as a unit. Where	contracts cover individual	
t and sickness) The image is a contingencies Section of the s	8	Bene	efit and contract type (check all applicable boxes)				
J HMO contract Sa(1) Sa(2) Sa(2) Sa(3) Sa(4) Sa(2) Sa(2) Sa(4) Sa(4		а	Health (other than dental or vision) b Dental	с	Vision	d X Life insurance	
J HMO contract Sa(1) Sa(2) Sa(2) Sa(3) Sa(4) Sa(2) Sa(2) Sa(4) Sa(4		e =		bility a	Supplemental unemployment	h ☐ Prescription drug	
9a(1) 9a(2) 9a(3) 9a(4) 9a(4) 9a(5) 9a(6) 9a(7) 9a(8) 9a(8		i				- 📙	
Same		느		~_	PPO contract	I I indemnity contract	
Same		m X	X Other (specify) ▶AD&D				
Same	0		ovience voted contracts.				
Same	9	•	erience-rated contracts:	00(1)		_	
Sa(3) Sa(4) Sa(4			. ,	· · · ·			
9a(4) 9b(1) 9b(2) 9b(3) 9b(4)			(3) Increase (decrease) in amount due but unpaid			_	
9b(1) 9b(2) 9b(3) 9b(4)					9a(4)		
9b(2) 9b(3) 9b(4)			Benefit charges (1) Claims paid				
9b(3) 9b(4) ention charges (on an accrual basis)			(2) Increase (decrease) in claim reserves				
ention charges (on an accrual basis) gc(1)(A) or other fees gc(1)(B) on costs gc(1)(C) gc(1)(D) gc(1)(E) er contingencies gc(1)(G) er refunds. (These amounts were paid in cash, or credited.) gc(2) at end of year: (1) Amount held to provide benefits after retirement gd(2) at end of year: (1) Amount held to provide benefits after retirement gd(3) funds due. (Do not include amount entered in line gc(2).) ge charges paid to carrier general g					9b(3))	
9c(1)(A) 9c(1)(B) 9c(1)(C) 9c(1)(D) 9c(1)(E) 9c(1)(F) 9c(1)(G) 9c(1)(G) 9c(1)(G) 9c(1)(G) 9c(1)(H) 9c(1)(H) 9c(1)(H) 9c(1)(G) 9c(
or other fees		С	Remainder of premium: (1) Retention charges (on an accrual basis)				
on costs 9c(1)(C) 9c(1)(D) 9c(1)(E) 9c(1)(F) 9c(1)(G) 9c(1)(G) 9c(1)(G) 9c(1)(H) 9c(1)(G) 9c(1)(H) 9c(1)(H) 9c(2) 9c(2) 9d(3)			(A) Commissions	9c(1)(A)			
9c(1)(D) 9c(1)(E) 9c(1)(F) 9c(1)(G) 9c(1)(G) 9c(1)(G) 9c(1)(H) 9c(1)(H) 9c(1)(H) 9c(2) at end of year: (1) Amount held to provide benefits after retirement 9d(1) 9d(2) 9d(3) funds due. (Do not include amount entered in line 9c(2).) 9e charges paid to carrier 9e charges paid to carrier 10a 66018			(B) Administrative service or other fees				
9c(1)(E) 9c(1)(F) 9c(1)(G) 9c(1)(G) 9c(1)(H) 9c(1)(H) 9c(1)(H) 9c(1)(H) 9c(1)(H) 9c(2) at end of year: (1) Amount held to provide benefits after retirement 9d(1) 9d(2) 9d(3) funds due. (Do not include amount entered in line 9c(2).) 9e charges paid to carrier 9e charges paid to carrier 10a 66018			(C) Other specific acquisition costs				
er contingencies			(D) Other expenses				
grefunds. (These amounts were paid in cash, or credited.)			(E) Taxes				
e refunds. (These amounts were paid in cash, or credited.) 9c(2) at end of year: (1) Amount held to provide benefits after retirement 9d(1) 9d(2) 9d(3) funds due. (Do not include amount entered in line 9c(2).) 9e charges paid to carrier 10a 66018 organization incurred any specific costs in connection with the acquisition or			(F) Charges for risks or other contingencies	0-(4)(0)			
e refunds. (These amounts were paid in cash, or credited.)			(G) Other retention charges	L	0.5/4\/!		
at end of year: (1) Amount held to provide benefits after retirement 9d(1) 9d(2) 9d(3) funds due. (Do not include amount entered in line 9c(2).) 9e charges paid to carrier 10a 66018 organization incurred any specific costs in connection with the acquisition or			· /	_			
9d(2) 9d(3) funds due. (Do not include amount entered in line 9c(2).) charges paid to carrier proganization incurred any specific costs in connection with the acquisition or							
funds due. (Do not include amount entered in line 9c(2).) charges paid to carrier funds due. (Do not include amount entered in line 9c(2).) charges paid to carrier funds due. (Do not include amount entered in line 9c(2).) 10a 66018							
tunds due. (Do not include amount entered in line 9c(2).) charges paid to carrier triganization incurred any specific costs in connection with the acquisition or							
charges paid to carrier						1	
organization incurred any specific costs in connection with the acquisition or	10		onexperience-rated contracts:	rea in line 90(2).) j		
organization incurred any specific costs in connection with the acquisition or					10a	66	018
		_				00	010
		_					
	Pa	a b Spec	Total premiums or subscription charges paid to carrier	n connection with	n the acquisition or unt	× No	66
				mplete Schedule	A? Yes	X No	
provide any information necessary to complete Schedule A?	12	If th	the answer to line 11 is "Yes," specify the information not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

			ERISA section 103(a)(2)		ion	This Fo	orm is Open to Public Inspection
For calendar plan year 20	18 or fiscal pla	in year beginning 01/01/2018		and en	iding 12/31	/2018	
A Name of plan CHILDRENS FRIEND AND SERVICE FLEXIBLE BENEFITS PLAN					e-digit number (PN) •	501
C Plan sponsor's name a CHILDRENS FRIEND AN	D SERVICE			05-	oyer Identifica 0258819		
		rning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		DMPANY				.	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered at	end of	(f)	Policy or From	contract year (g) To
36-2739571	79413	753421	policy or contract	•	01/01/2018		12/31/2018
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, b	rokers, and	other persons in
(a) Total a	amount of com	imissions paid		(b) To	otal amount o	f fees paid	
	4144						
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name	and address of the agent, broke	r, or other person to whor	n commiss	ions or fees v	vere paid	
PROVIDER INSURANCE (GROUP LLC		OULD ST STE 130 DHAM, MA 02494				
(b) Amount of sales ar	nd hase	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
	4144						3
	(a) Name	and address of the agent, broke	r, or other person to whor	n commiss	ions or fees v	were paid	
(b) Amount of sales ar			ees and other commission				
commissions pai	id	(c) Amount		(d) Purpose	е		(e) Organization code

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts v	vith each carrier may be	e treated a	as a unit for purposes of
		this report.				
		ent value of plan's interest under this contract in the general account at year			4	
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts 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 co			6d	
		retention of the contract or policy, enter amount.			-	
		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	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		-				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:	7-(4)			
		(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) 7e(4)			
		(4) Other (specify below)	. /e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

P	art I	II	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individ	group	of e	ses i	if such	contrac	cts are	expe	erience-rated as a ui	nit. Where o	contrac	ts cover individual	
8	Bene	efit a	nd contract type (check all applicable boxes)												
	a	Н	ealth (other than dental or vision)	b	De	ental				С	Vision		d	Life insurance	
	е	Te	emporary disability (accident and sickness)	f 🗏	- Lo	ong-te	erm dis	ability		g☐	Supplemental uner	mployment	h∏	Prescription drug	
	i 5	_	op loss (large deductible)	ιĖ		-	contract	-		- 느	PPO contract	, ,	- 브	Indemnity contract	
	L	_		, __]	WIO 0	ontidot			., □	110 contidot		•⊔	machinity contract	
	m		ther (specify)												
a	Evne	rion	ce-rated contracts:												
,	•		niums: (1) Amount received						9a(1)						
			ncrease (decrease) in amount due but unpaid						9a(2)						
			ncrease (decrease) in unearned premium res						9a(3)	_					
		` '	Earned ((1) + (2) - (3))									9a(4)			
		. ,	efit charges (1) Claims paid						9b(1)			, , ,			
		(2) I	ncrease (decrease) in claim reserves												
		(3) I	ncurred claims (add (1) and (2))									9b(3)			
		(4) (Claims charged									9b(4)			
	С	Ren	nainder of premium: (1) Retention charges (c	n an	accr	rual b	oasis)								
			(A) Commissions						0c(1)(_					
			(B) Administrative service or other fees						0c(1)(l						
			(C) Other specific acquisition costs						0c(1)(0				_		
			(D) Other expenses						0c(1)(l 0c(1)(l	_			_		
			(E) Taxes					_	c(1)(I						
			(F) Charges for risks or other contingencies (G) Other retention charges)c(1)((_		
			(H) Total retention(H)									9c(1)(H	1)		
			Dividends or retroactive rate refunds. (These							_			-		
	d		tus of policyholder reserves at end of year: (1												
	u		Claim reserves												
		` '	Other reserves												
	е	` '	dends or retroactive rate refunds due. (Do n												
10			perience-rated contracts:									•			
	а	Tota	al premiums or subscription charges paid to o	arrier	r							10a		41	505
	_	rete	e carrier, service, or other organization incurrention of the contract or policy, other than repeature of costs.									10b			
P	Sper	cify r		orted	In Pa	art I,	line 2 a	above,	report	amo	unt	105			
11	Did	l the	insurance company fail to provide any inform	nation	nec	cessa	arv to co	mplete	e Sche	dule	Α?	Yes	X N	lo	
			nswer to line 11 is "Yes," specify the informat					, iipiett	JOHE	uule	,				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

Service Provider Information

File as an attachment to Form 5500.

OMB No. 1210-0110

2018

This Form is Open to Public Inspection.

For calendar plan year 2018 or fiscal plan year beginning 01/01/2018	and ending 12/31/2018
A Name of plan	B Three-digit
CHILDRENS FRIEND AND SERVICE FLEXIBLE BENEFITS PLAN	plan number (PN) 501
	plan number (114)
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
CHILDRENS FRIEND AND SERVICE	05-0258819
	00 0200010
Part I Service Provider Information (see instructions)	
Tart Corrido Frontaci information (coo monactions)	
You must complete this Part, in accordance with the instructions, to report the information re	quired for each person who received, directly or indirectly, \$5,000
or more in total compensation (i.e., money or anything else of monetary value) in connection	
plan during the plan year. If a person received only eligible indirect compensation for which	
answer line 1 but are not required to include that person when completing the remainder of t	nis Part.
1 Information on Persons Receiving Only Eligible Indirect Compensati	
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of the	, , , , , , , , , , , , , , , , , , ,
indirect compensation for which the plan received the required disclosures (see instructions to	for definitions and conditions)
b If you answered line 1a "Yes," enter the name and EIN or address of each person providing received only eligible indirect compensation. Complete as many entries as needed (see inst	•
(b) Enter name and EIN or address of person who provided you disc	closures on eligible indirect compensation
(b) Fatar ages and FIN an address of manage who may ideal you dis	
(b) Enter name and EIN or address of person who provided you disc	closures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disc	closures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disc	closures on eligible indirect compensation

Schedule C (Form 5500) 2018	Page 2- 1
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	ho provided you disclosures on eligible indirect compensation

	Schedule C (Form 550	00) 2018		Page 3 - 1		
answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN or	address (see instructions)		
UNITED H	IEALTHCARE SERVIC	CES, INC.		REN ROAD EAST TONKA, MN 55343		
41-128924	15					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 49	CLAIMS PROCESSOR	208955	Yes X No [Yes No 🛚	0	Yes X No
			a) Enter name and EIN or	address (see instructions)		
27-200596	R INSURANCE GROU	JP LLC		OULD ST STE 130 IAM, MA 02494		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
55	BROKER	0	Yes X No	Yes No 🗓	37632	Yes No X
			a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you	(h) Did the service provider give you a formula instead of an amount or estimated amount?

Yes No

Yes No

compensation for which you answered "Yes" to element (f). If none, enter -0-.

Yes No

Page	3	-	2
Page	3	-	2

answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
(1.6., 111011	ey or arrything else or	·		r address (see instructions)	plan during the plan year. (Si	ee manuchons).
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(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	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Page 4 -

Part I Service Provider Information (continued)

or provides contract administrator, consulting, custodial, investment advisory, investment madvestions for (a) each source from whom the service provider received \$1,000 or more in incorprovider gave you a formula used to determine the indirect compensation instead of an amomany entries as needed to report the required information for each source.	direct compensation and (b) each s	ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(a) Describe the indirect	compensation, including any
(a) Effect famile and Effy (address) of source of malifect compensation	formula used to determine	e the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe 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
	(2) 2	
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

D	art II Service Providers Who Fail or Refuse to	Drovido Inform	mation
4			
4	this Schedule.	ach service provide	r who failed or refused to provide the information necessary to complete
	(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
	(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
	(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
	(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
	(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
	(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

Page 6 -	l
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Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)			
	No	(complete as many entries as needed)	b EIN:
a c	Name: Position		D EIN:
d	Addres		e Telephone:
u	Addres	SS.	e releptione.
Explanation:			
а	Name:		b EIN:
С	Positio		
d	Addres		e Telephone:
			·
Explanation:			
а	Name:		b EIN:
С	Positio		
d	Addres	SS:	e Telephone:
Explanation:			
	Mana		b EIN:
a C	Name: Position		D EIN:
d	Addres		e Telephone:
u	Addres	5.	• тетернопе.
Explanation:			
а	Name:		b EIN:
С	Positio	n:	
d	Addres		e Telephone:
-			
Explanation:			