Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Annual Return/Report of Employee Benefit Plan

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

➤ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2018

	Administration	the instructi	ons to the Form 55	000.	-		
Pensio	on Benefit Guaranty Corporation				This Form is Open to Public Inspection		
Part I	Annual Report Ide	ntification Information					
For caler	ndar plan year 2018 or fiscal	plan year beginning 01/01/2018		and ending 12/31/20	018		
A This r	return/report is for:	a multiemployer plan	participating er	mployer information in accor	this box must attach a list of rdance with the form instructions.)		
		a single-employer plan	a DFE (specify	')			
B This r	return/report is:	the first return/report	the final return	•			
		an amended return/report	a short plan ye	ear return/report (less than 1	2 months)		
C If the	plan is a collectively-bargain	ned plan, check here					
D Chec	k box if filing under:	Form 5558	automatic exten	nsion	the DFVC program		
		special extension (enter description)					
Part II	Basic Plan Informa	ation—enter all requested informatio	n				
	ne of plan	VEE DENIETE DI ANI			1b Three-digit plan number (PN) ▶	01	
LEAFLY	/ HOLDINGS, INC. EMPLO\	YEE BENEFII PLAN			1c Effective date of plan 01/01/2014		
2a Plan sponsor's name (employer, if for a single-employer plan)2b Employer IdentificationMailing address (include room, apt., suite no. and street, or P.O. Box)Number (EIN)City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)45-3834135							
LEAFLY	HOLDINGS, INC.				2c Plan Sponsor's telephone number 206-453-0766		
	MBIA ST, STE 200 E, WA 98014	71 COLUM SEATTLE,	2d Business code (see instructions) 551112				
Caution	: A penalty for the late or in	ncomplete filing of this return/repor	t will be assessed (unless reasonable cause i	s established.		
		penalties set forth in the instructions, I as the electronic version of this return					
SIGN	Filed with authorized/valid e	lectronic signature.	06/24/2019	MISTY BENDER			
HERE	Signature of plan adminis	strator	Date	Enter name of individual s	signing as plan administrator		
SIGN HERE							
HERE	Signature of employer/pl	an sponsor	Date	Enter name of individual s	signing as employer or plan sponso	or	
SIGN HERE						_	

Date

Signature of DFE

Enter name of individual signing as DFE

	Form 5500 (2018)	Pa	ge 2		
3a	Plan administrator's name and address Same as Plan Sponsor			3b Administrate	
LE	AFLY HOLDINGS, INC.			45-3834 3c Administrate	
	COLUMBIA ST, STE 200			number	·
SE	ATTLE, WA 98014			206-45	3-0766
4	If the name and/or EIN of the plan sponsor or the plan name has changed si enter the plan sponsor's name, EIN, the plan name and the plan number from			4b EIN 45-356	61660
а	Sponsor's name PRIVATEER HOLDINGS, INC.			4d PN	
С	Plan Name PRIVATEER HOLDINGS, INC. EMPLOYEE BENEFIT PLAN			501	
5	Total number of participants at the beginning of the plan year			5	207
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2) , 6b , 6c , and 6d).	d (welfare plans	s complete only lines 6a(1),		
а(1) Total number of active participants at the beginning of the plan year			6a(1)	207
a(2) Total number of active participants at the end of the plan year			6a(2)	175
b	Retired or separated participants receiving benefits			6b	ę
С	Other retired or separated participants entitled to future benefits			6c	Ę
d	Subtotal. Add lines 6a(2), 6b, and 6c			6d	189
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefits.		6e	
f	Total. Add lines 6d and 6e			6f	189
g	Number of participants with account balances as of the end of the plan year complete this item)			6g	
h	Number of participants who terminated employment during the plan year with	h accrued bene	efits that were	6h	
7	less than 100% vested			-	
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from the L	ist of Plan Characteristics Co	des in the instruction	ons:
b	If the plan provides welfare benefits, enter the applicable welfare feature cod 4A 4D 4E 4B 4F 4H 4Q	T			ns:
9a	Plan funding arrangement (check all that apply) (1)	9b Plan be (1)	enefit arrangement (check all the nefit arrangement)	nat apply)	
	(2) Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3) insurance contrac	ets
	(3) Trust	(3)	Trust		
10	(4) General assets of the sponsor	(4)	General assets of the	•	- itti
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	_		iber attached. (Se	e instructions)
а	Pension Schedules (1) P (Potiroment Plan Information)		al Schedules	rmation)	
	(1) R (Retirement Plan Information)	(1) (2)	H (Financial Info	rmation) mation – Small Pla	un)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2) (3)	X 4 A (Insurance Info		"' <i>')</i>
	Purchase Plan Actuarial Information) - signed by the plan actuary	(4)	C (Service Providence in C		
		(5)		iting Plan Informati	on)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(6)		nsaction Schedules	

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

			ERISA section 103(a)(2)		tion	This For	m is Open to Public Inspection	
For calendar plan year 20	18 or fiscal pla	an year beginning 01/01/2018		and er	nding 12/3	1/2018		
A Name of plan LEAFLY HOLDINGS, INC	C. EMPLOYEE	BENEFIT PLAN			e-digit n number (PN	N) •	501	
C Plan sponsor's name a LEAFLY HOLDINGS, INC		ne 2a of Form 5500			oyer Identifica -3834135	ation Number	(EIN)	
		rning Insurance Contra A. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca PREMERA BLUE CROSS	rrier							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or c	contract year	
(b) Liiv	code	identification number	policy or contract		(f)	From	(g) To	
91-0499247	47570	4012777	325		01/01/2018	8	12/31/2018	
2 Insurance fee and com- descending order of the		nation. Enter the total fees and t	otal commissions paid. Li	st in line 3	the agents,	brokers, and c	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
68894 2596							2596	
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).				
		and address of the agent, broke	·		sions or fees	were paid		
THE PARTNERS GROUP		1174 POR	0 SW 68TH PKWY, STE 2 TLAND, OR 97223	200				
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpos			(e) Organization code	
	68894	2596	PREFERRED PRODUCE	R PROGR	AM		3	
	(a) Name	and address of the agent, broke	er, or other person to whor	n commiss	sions or fees	were paid		
	(4)		,,					
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid				
commissions pa		(c) Amount	(d) Purpose			(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

F	Part	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 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.			0 4					
		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 termination	ating plan, chec	ck here						
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	. 7c(1)	<u>.</u>						
		(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		<u> </u>	7c(6)					
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d					
	е	Deductions:								
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)							
		(2) Administration charge made by carrier	. 7e(2)							
		(3) Transferred to separate account	. 7e(3)							
		(4) Other (specify below)	. 7e(4)							
		•								
	_	(5) Total deductions			7e(5)					
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f					

P	art	III	Welfare Benefit Contract Informal If more than one contract covers the same		same emplo	over(s) or members of t	the same er	mnlovee organizations(s)
			the information may be combined for repor employees, the entire group of such individ	ting purposes if such conti	racts are expe	érience-rated as a unit	. Where co	ontracts cover individual	,,
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	y g	Supplemental unemp	oloyment	h Prescription drug	
	i İ		op loss (large deductible)	j	, <u> </u>	PPO contract	,	I Indemnity contract	t
	m	_ 	ther (specify)		_	1			
			ce-rated contracts:	ı					
	а		niums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpai						
			ncrease (decrease) in unearned premium res	· · · · · · · · · · · · · · · · · · ·			0.74		
	L		Earned ((1) + (2) - (3))				9a(4)		
	b		nefit 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	0-(4)(A)				
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)				
			(C) Other specific acquisition costs		9c(1)(D)				
			(E) Taxes		9c(1)(E)				
			(F) Charges for risks or other contingencies.		9c(1)(F)				
			(G) Other retention charges						
			(H) Total retention	•			9c(1)(H)		
			Dividends or retroactive rate refunds. (These	_	_		9c(2)		
	d		tus of policyholder reserves at end of year: (1				9d(1)		
	u		Claim reserves	•			9d(2)		
		. ,	Other reserves				9d(3)		
	е	` '	dends or retroactive rate refunds due. (Do n				9e		
10			perience-rated contracts:	<u> </u>		,			
-	а		al premiums or subscription charges paid to o	carrier			10a	17	22340
	b		e carrier, service, or other organization incur						
		rete	ention of the contract or policy, other than repnature of costs.				10b		
	Орс	ony i	lature of costs.						
_	4	11.7	Description of Information						
	art		Provision of Information						
			insurance company fail to provide any inform		ete Schedule	A?	Yes	X No	
12	If t	he a	nswer to line 11 is "Yes," specify the informat	ion not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

			ERISA section 103(a)(2)		.1011	Inis For	m is Open to Public Inspection	
For calendar plan year 20	18 or fiscal pla	an year beginning 01/01/2018		and en	ding 12/3	1/2018		
A Name of plan LEAFLY HOLDINGS, INC	. EMPLOYEE	BENEFIT PLAN			e-digit number (PN	N) •	501	
C Plan sponsor's name at LEAFLY HOLDINGS, INC		ne 2a of Form 5500			oyer Identifica 3834135	ation Number	(EIN)	
on a separa		rning Insurance Contract A. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca VISION SERVICE PLAN	rrier							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or c	contract year	
(b) EIN	code	identification number	policy or contract		(f)	From	(g) To	
23-7089668	53031	30064675	199		01/01/2018	8	12/31/2018	
2 Insurance fee and come descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents,	brokers, and o	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
1088 0								
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).				
		and address of the agent, broke			ions or fees	were paid		
THE PARTNERS GROUP		1174 POR	0 SW 68TH PKWY, STE 2 TLAND, OR 97223	200				
(b) Amount of sales ar	nd hase	F	ees and other commissior	s paid				
commissions pai		(c) Amount		d) Purpose	е		(e) Organization code	
	1088	0					3	
	(a) Name	and address of the agent, broke	er, or other person to whor	n commiss	ions or fees	were paid		
	(a) Hamo	and address of the agon, broke	n, or other poledition miles		10110 01 1000	wore paid		
(b) Amount of sales ar	nd hase	F-	ees and other commissior	s paid				
commissions pai		(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	
		For any distribution and section and the section of	(-)
(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

F	Part	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 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.			0 4					
		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 termination	ating plan, chec	ck here						
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	. 7c(1)	<u>.</u>						
		(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		<u> </u>	7c(6)					
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d					
	е	Deductions:								
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)							
		(2) Administration charge made by carrier	. 7e(2)							
		(3) Transferred to separate account	. 7e(3)							
		(4) Other (specify below)	. 7e(4)							
		•								
	_	(5) Total deductions			7e(5)					
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f					

P	art II	ı	Welfare Benefit Contract Informa									
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ing p	urp	oses if such con	racts are	expe	rience-rated as a unit	Where c	ontrac	ts cover individual
8	Benef	fit an	d contract type (check all applicable boxes)									
	а	Hea	alth (other than dental or vision)	b		ental		CX	Vision		d	Life insurance
	е □	Ter	mporary disability (accident and sickness)	f	ĪL	ong-term disabil		g∏	Supplemental unemp	lovment	h∏	Prescription drug
	: H		p loss (large deductible)	i È	=	IMO contract	-		PPO contract	,	ıΗ	Indemnity contract
	. H		· · · · ·	, _[」	iivio contract		`` ∐	110 contract		•⊔	machinity contract
	m	Otr	ner (specify)									
9	Evnor	iono	o rotad contracto:									
Э	•		e-rated contracts: ums: (1) Amount received				02/1					
			crease (decrease) in amount due but unpaid									
	,	,	crease (decrease) in unearned premium res									
			arned ((1) + (2) - (3))							9a(4)		
	- `	,	efit charges (1) Claims paid									
			crease (decrease) in claim reserves				7-1					
	(;	ý 3) In	curred claims (add (1) and (2))							9b(3)		
	(4	4) CI	aims charged							9b(4)		
	C	Rem	ainder of premium: (1) Retention charges (c	n an	acc	rual basis)						
		(/	A) Commissions				9c(1)(4)				
		(1	B) Administrative service or other fees									
		(0	C) Other specific acquisition costs					_			_	
		,	D) Other expenses				0 - /4 \ / !					
		,	E) Taxes					_			_	
			F) Charges for risks or other contingencies				A (4) (4				_	
		,	G) Other retention charges							9c/1\/H	· -	
	,	,	H) Total retention			_		_		9c(1)(H	'	
			ividends or retroactive rate refunds. (These			_				9c(2)		
			us of policyholder reserves at end of year: (1	•		•				9d(1)		
	,	,	laim reservesther reserves							9d(2) 9d(3)		
	,	` '	lends or retroactive rate refunds due. (Do n							9e		
10			erience-rated contracts:	00 1110	, au	o amount ontolo	<u> </u>	<u> </u>	,			
			premiums or subscription charges paid to o	arrie	r					10a		19578
	b ı	f the	carrier, service, or other organization incur	ed a	nv s	specific costs in o	connection	with	the acquisition or			
	r	eten	ature of costs.		•	•			'	10b		
	Opec	ily ilo	duie of costs.									
P	art I\	/	Provision of Information									
				otio-		coccany to comm	loto Saba	dula	лэ П	Yes	X N	0
			nsurance company fail to provide any inform				iele SCN6	uuie	Λ:	103	^ IN	
12	it the	e ans	swer to line 11 is "Yes," specify the informat	on n	ot p	roviaea. 🔊						

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

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).							This Form is Open to Public Inspection		
For calendar plan year 20	018 or fiscal pla	an year beginning 01/01/2018	-	and en	ding 12/31	/2018			
A Name of plan LEAFLY HOLDINGS, IN	C. EMPLOYEE	BENEFIT PLAN			e-digit number (PN) •	501		
C Plan sponsor's name LEAFLY HOLDINGS, INC		ne 2a of Form 5500		•	oyer Identifica 3834135	ation Number	(EIN)		
on a sepa	rate Schedule	rning Insurance Contract A. Individual contracts grouped as							
1 Coverage Information:									
(a) Name of insurance ca						D. II			
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered at		(0)	•	contract year		
	code	identification number	policy or contract	year	(†)	From	(g) To		
91-0621480	47341	12700	193 01/01/201				12/31/2018		
2 Insurance fee and com descending order of the		nation. Enter the total fees and total	al commissions paid. Lis	st in line 3	the agents, b	orokers, and	other persons in		
(a) Total	amount of com			(b) To	otal amount o	f fees paid			
		7160					0		
3 Persons receiving con	nmissions and	fees. (Complete as many entries	as needed to report all p	ersons).					
	(a) Name	and address of the agent, broker,	or other person to whon	n commiss	ions or fees v	were paid			
THE PARTNERS GROUP			SW 68TH PKWY, STE 2 AND, OR 97223	00					
(b) Amount of sales a	and hase	Fee	s and other commission	s paid					
commissions pa		(c) Amount	(d) Purpos	е		(e) Organization code		
	7160	0					3		
	(a) Name	and address of the agent, broker,	or other person to whom	n commiss	ions or fees v	were paid			
	,,		,			,			
(b) Amount of sales a	ind base	Fee	s and other commission	s paid					
commissions pa		(c) Amount	(d) Purpos	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	
			(5)
(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	, 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) Na			
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(4) - 3-1-2-3	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
	•	Fees and other commissions paid	
(b) Amount of sales and base		·	(e) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(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	treated 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		ooguioition or	6d	_
		retention of the contract or policy, enter amount.			<u> </u>	
		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 termination	ating plan, checl	k here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separ	ate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ite participation g	juarantee		
		(3) guaranteed investment (4) other				
		_				
	b	Balance at the end of the previous year			7b	_
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
		(6)Total additions			′c(6)	
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:	- (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)	
		(5) Total deductions			'e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	_

the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. 8 Benefit and contract type (check all applicable boxes) a	employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. Benefit and contract type (check all applicable boxes) a	P	art III	Welfare Benefit Contract Inform					
a Health (other than dental or vision) b Dental c Vision d Life insurance h Prescription drug i Stop loss (large deductible) j HMO contract k PPO contract l Indemnity contract m Other (specify) Experience-rated contracts: a Premiums: (1) Amount received. (2) Increase (decrease) in amount due but unpaid. (3) Increase (decrease) in unearned premium reserve. (4) Earned ((1) + (2) - (3)). b Benefit charges (1) Claims paid. (2) Increase (decrease) in claim reserves. (3) Increase (decrease) in claim reserves. (3) Increase (decrease) in claim reserves. (4) Claims charged. (5) Administrative service or other fees. (6) Administrative service or other fees. (9) CO Other specific acquisition costs. (9) Congress of (1) Claims of acquisition costs. (1) Charges for risks or other contingencies. (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited). (2) Claim reserves. 9d(1) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement. 9d(3) Supplemental unemployment. A PPO contract L I Indemnity contract I Inde	a			the information may be combined for repor	ting purposes if such con	tracts are expe	erience-rated as a unit. Where c	ontrac	ts cover individual
e	e	8	Benefit	and contract type (check all applicable boxes)					
e	e		а∏⊦	Health (other than dental or vision)	b X Dental	с□	Vision	d□	Life insurance
i Stop loss (large deductible) j HMO contract k PPO contract l Indemnity contract m Other (specify) Experience-rated contracts: a Premiums: (1) Amount received	i				_ H	itv a \square	Supplemental unemployment	h∏	Prescription drug
## Dither (specify) ## Disperience-rated contracts: ## Premiums: (1) Amount received	Experience-rated contracts: a Premiums: (1) Amount received								,
## Premiums: (1) Amount received	Experience-rated contracts: a Premiums: (1) Amount received		=		I HIVIO CONTIACT	~ □	FFO Contract	'⊔	indenning contract
a Premiums: (1) Amount received	a Premiums: (1) Amount received		m ∐ (Other (specify)					
a Premiums: (1) Amount received	a Premiums: (1) Amount received	_							
(2) Increase (decrease) in amount due but unpaid	(2) Increase (decrease) in amount due but unpaid	9	•			0-(4)		_	
(3) Increase (decrease) in unearned premium reserve 9a(3) 0 (4) Earned ((1) + (2) - (3))	(3) Increase (decrease) in unearned premium reserve			` '					
(4) Earned ((1) + (2) - (3)) b Benefit charges (1) Claims paid	(4) Earned ((1) + (2) - (3))		` '	` ,					
b Benefit charges (1) Claims paid 9b(1) 129060 (2) Increase (decrease) in claim reserves 9b(2) 1000 (3) Incurred claims (add (1) and (2)) 9b(3) 1 (4) Claims charged 9b(4) 1 C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions 9c(1)(A) 7160 (B) Administrative service or other fees 9c(1)(B) 21830 (C) Other specific acquisition costs 9c(1)(C) 0 (D) Other expenses 9c(1)(C) 0 (E) Taxes 9c(1)(E) 0 (F) Charges for risks or other contingencies 9c(1)(F) 0 (G) Other retention charges 9c(1)(G) 0 (H) Total retention . 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were □ paid in cash, or □ credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves. 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e	Description							J	16105
(2) Increase (decrease) in claim reserves	(2) Increase (decrease) in claim reserves		_ ` '	***					10103
(3) Incurred claims (add (1) and (2))	(3) Incurred claims (add (1) and (2)) 13006i (4) Claims charged 9b(4) 13006i C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions 9c(1)(B) 21830 (C) Other specific acquisition costs 9c(1)(C) 0 (D) Other expenses 9c(1)(C) 0 (E) Taxes 9c(1)(E) 0 (F) Charges for risks or other contingencies 9c(1)(F) 0 (G) Other retention charges 9c(1)(F) 0 (H) Total retention (harges 9c(1)(F) 0 (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) 500 (3) Other reserves 9d(3) 9e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)) 9e O Nonexperience-rated contracts: 10a Total premiums or subscription charges paid to carrier 10a b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. 10b								
(4) Claims charged	(4) Claims charged		` '	,					13006
C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions	C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions								
(A) Commissions 9c(1)(A) 7160 (B) Administrative service or other fees 9c(1)(B) 21830 (C) Other specific acquisition costs 9c(1)(C) 0 (D) Other expenses 9c(1)(D) 0 (E) Taxes 9c(1)(E) 0 (F) Charges for risks or other contingencies 9c(1)(F) 0 (G) Other retention charges 9c(1)(G) 0 (H) Total retention 9c(1)(G) 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves 9d(3) 9e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e	(A) Commissions		` '	<u> </u>			00(4)		
(B) Administrative service or other fees	(B) Administrative service or other fees		•	. , , , , ,	,	9c(1)(A)	716	0	
(C) Other specific acquisition costs 9c(1)(C) 0 (D) Other expenses 9c(1)(D) 0 (E) Taxes 9c(1)(E) 0 (F) Charges for risks or other contingencies 9c(1)(F) 0 (G) Other retention charges 9c(1)(F) 0 (H) Total retention 9c(1)(H) 0 (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e	(C) Other specific acquisition costs (D) Other expenses			()					
(D) Other expenses	(D) Other expenses			` '		0 (4)(0)		0	
(F) Charges for risks or other contingencies	(F) Charges for risks or other contingencies						(0	
(G) Other retention charges	(G) Other retention charges 9c(1)(G) 0 (H) Total retention			(E) Taxes		9c(1)(E)	(0	
(H) Total retention	(H) Total retention			(F) Charges for risks or other contingencies.				0	
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)	(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) 5000 (3) Other reserves. 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e 0 Nonexperience-rated contracts: 10a b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. 10b			(G) Other retention charges		9c(1)(G)		_	
d Status 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) e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e	d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) 5000 (3) Other reserves			(H) Total retention			9c(1)(H)	2899
(2) Claim reserves	(2) Claim reserves		(2)) Dividends or retroactive rate refunds. (These	e amounts were 🗌 paid i	n cash, or 🔲 d	credited.) 9c(2)		
(3) Other reserves	(3) Other reserves		d St	atus of policyholder reserves at end of year: (1	I) Amount held to provide	benefits after	retirement 9d(1)		
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		(2) Claim reserves			9d(2)		500
	Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier		•	,					
40 N	Total premiums or subscription charges paid to carrier				ot include amount entere	d in line 9c(2) .) 9e		
	b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	10							
Total premiums or subscription charges paid to carrier	retention of the contract or policy, other than reported in Part I, line 2 above, report amount		a To	otal premiums or subscription charges paid to	carrier		10a	_	
retention of the contract or policy, other than reported in Part I, line 2 above, report amount			re	tention of the contract or policy, other than rep			•	\perp	
Part IV Provision of Information	of Did the become a common fell to marche and before all to the Color of the Color					lete Schedule	A? Yes	X N	10
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	1. But the internation company has to provide any internation recorded by the company to company to the provide any internation recorded by the company to the provide any internation recorded by the company to the provide any internation recorded by the company to the provide any internation recorded by the company to the provide any internation recorded by the company to the provide any internation recorded by the company to the provide any internation recorded by the company to t	12	If the	answer to line 11 is "Yes," specify the informat	ion not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2018

This Form is Open to Public Inspection

For calendar p	olan year 2018	8 or fiscal plan	year beginning 01/01/2018		and en	ding 12/31/2018	
A Name of plan LEAFLY HOLDINGS, INC. EMPLOYEE BENEFIT PLAN					B Three	e-digit number (PN)	501
C Plan spons		shown on line	2a of Form 5500		-	yer Identification Number 3834135	(EIN)
Part I			ning Insurance Contract Individual contracts grouped as				
1 Coverage I	nformation:						
(a) Name of in GUARDIAN LIF			Y OF AMERICA				
(b) E	INI	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a		Policy or c	ontract year
(b) E	IIN	code	identification number	policy or contrac		(f) From	(g) To
13-5123390		64246	515917	177		01/01/2018	12/31/2018
	ee and comm		tion. Enter the total fees and tota	I commissions paid. Li	ist in line 3	the agents, brokers, and c	other persons in
	(a) Total ar	mount of comm			(b) To	otal amount of fees paid	
			17453				0
3 Persons re	ceiving comm	nissions and fe	es. (Complete as many entries a	as needed to report all	persons).		
		(a) Name ar	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees were paid	
C2 CENTRIC			PO BOX GRAND	(6824 RAPIDS, MI 49516			
(b) Amoun	it of sales and	d base	Fees	and other commissions paid			
` '	missions paid	l	(c) Amount		(d) Purpose	e	(e) Organization code
		104	0				3
		(a) Name ar	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees were paid	
THE PARTNER	RS GROUP	(*)	11740 S	SW 68TH PKWY, STE 2 AND, OR 97223			
(b) Amount of sales and base Fees and other cor					ns paid		
	it of sales and missions paid		(c) Amount	es and other commissions paid (d) Purpose			(e) Organization code
		14430	0				3
For Paperwor	rk Reduction	Act Notice, s	ee the Instructions for Form 55	500.		Sche	dule A (Form 5500) 2018 v. 171027

Schedule A	(Form	5500	2018
Scriedule A	(1 01111	5500	/ 2010

Page 2	-	1	
Page 4	4 -	1	

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

131 TREMONT ST, 3RD FLOOR
BOSTON, MA 02111

DAILYFEATS INC

		Francisco de disconocción de la constantida del constantida de la constantida de la constantida del constantida de la co	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
2919	0		3
(a) Nam	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(0)
(b) Amount of sales and base			(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nam	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(a) Nam	ie and dadress of the agent, broker	, or other person to whom commissions or rece were paid	
			T-
4		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commodiche para			0000
(a) Name	and address of the annual bushes		
(a) Nam	ie 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		(d) Purpose	Organization
commissions paid	(c) Amount	(u) ruipose	code

Part II		II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	treated 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		ooguioition or	6d	_
		retention of the contract or policy, enter amount.			<u> </u>	
		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 termination	ating plan, checl	k here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separ	ate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ite participation g	juarantee		
		(3) guaranteed investment (4) other				
		_				
	b	Balance at the end of the previous year			7b	_
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
		(6)Total additions			′c(6)	
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:	- (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)	
		(5) Total deductions			'e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	_

P	art l	II	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individuals.	grou ting p	ip of purp	oses if such	contra	cts are ex	ре	rience-rated as a uni	t. Where c	contract	s cover individual	
8	Ben	efit a	and contract type (check all applicable boxes)											
	а	Не	ealth (other than dental or vision)	b		Dental		С	П	Vision		d X	Life insurance	
	e	_	emporary disability (accident and sickness)	f	ΧI	ona-term dis	sability	g	Ħ	Supplemental unem	plovment	h∏	Prescription drug	
	i [_		_		HMO contrac	-		므	PPO contract	proymont	- =		
	L	_	op loss (large deductible)				ι	^	Ш	PPO Contract		'⊔	Indemnity contract	
	m	O	ther (specify) ACCIDENTAL DEATH AND	DISI	MEN	MBERMENT								
0	- Luna	rion	as rated contractor											
9	•		ce-rated contracts:					00/4)						
			niums: (1) Amount receivedncrease (decrease) in amount due but unpai					9a(1) 9a(2)						
			ncrease (decrease) in amount due but unpair ncrease (decrease) in unearned premium res					9a(3)						
		` '	Earned ((1) + (2) - (3))								9a(4)			_
	_	. ,	nefit charges (1) Claims paid						Τ		. 3u(+)			
			ncrease (decrease) in claim reserves											
			ncurred claims (add (1) and (2))								. 9b(3)			_
			Claims charged								9b(4)			_
	С	` '	nainder of premium: (1) Retention charges (c											П
			(A) Commissions			•	_	9c(1)(A)						
			(B) Administrative service or other fees				_	9c(1)(B)	_					
			(C) Other specific acquisition costs					Oc(1)(C)						
			(D) Other expenses					c(1)(D)						
			(E) Taxes					9c(1)(E)						
			(F) Charges for risks or other contingencies.					9c(1)(F)						
			(G) Other retention charges					9c(1)(G)			1			
			(H) Total retention			_					. 9c(1)(H	I)		
		(2) I	Dividends or retroactive rate refunds. (These	amo	ount	ts were p	aid in c	ash, or	С	redited.)	9c(2)			
	d	Stat	tus of policyholder reserves at end of year: (1) Am	nour	nt held to pro	vide be	enefits afte	er ı	retirement	. 9d(1)			
		(2)	Claim reserves								. 9d(2)			
		` '	Other reserves											
40			dends or retroactive rate refunds due. (Do n	ot inc	clud	le amount en	tered ir	n line 9c(2	2) .))	. 9e			
10			perience-rated contracts:								40.			_
	а		al premiums or subscription charges paid to o								. 10a		972	95
	b Spe	rete	e carrier, service, or other organization incurention of the contract or policy, other than replature of costs.								. 10b			
	Spe	rete	Provision of Information	orted	in F	Part I, line 2	above,	report am	nou	unt				
11	Dic	l the	insurance company fail to provide any inform	nation	n ne	ecessary to c	omplet	e Schedu	le .	Α? Π	Yes	X N	0	
			nswer to line 11 is "Yes," specify the informat											_

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security

Annual Return/Report of Employee Benefit Plan

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

> ▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

	Administration					F !- O (- D-			
Pensio	n Benefit Guaranty Corporation				inis	Form is Open to Pu Inspection	JDIIC		
Part I	Annual Report Ider	ntification Information							
For caler	ndar plan year 2018 or fiscal	plan year beginning 01/01/2018		and ending 12/31/20)18				
A This r	eturn/report is for:	x a multiemployer plan		loyer plan (Filers checking the species of the control of the cont			ns.)		
		a single-employer plan	a DFE (specify)					
B This r	eturn/report is:	the first return/report	the final return	report/					
		an amended return/report	a short plan ye	ar return/report (less than 12	2 months))			
C If the	plan is a collectively-bargain	ed plan, check here				•			
D Chec	k box if filing under:	Form 5558	automatic exter	sion	the	e DFVC program			
		special extension (enter description)							
Part II		ation—enter all requested informatio	n						
	ie of plan ′ HOLDINGS, INC. EMPLOY	EE BENEFIT PLAN			1b	Three-digit plan number (PN) ▶	501		
					1c	Effective date of pl	an		
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)						2b Employer Identification Number (EIN) 45-3834135			
LEAFLY HOLDINGS, INC.					2c	2c Plan Sponsor's telephone number 206-453-0766			
	MBIA ST, STE 200 E, WA 98014	71 COLUM SEATTLE,	IBIA ST, STE 200 WA 98014		2d	Business code (seinstructions) 551112	е		
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									
HEKE	Signature of plan adminis	strator	Date	Enter name of individual signing as plan administrator					
SIGN HERE	Rommie Cal	laghan	6/14/19	Rommie Callaghan					
TILIXL	Signature of employer/pla	an sponsor	Date	Enter name of individual s	igning as	employer or plan sp	onsor		
SIGN									
HERE	Signature of DFE		Date	Enter name of individual s	igning as	DFE			