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

Part I Annual Report Id	dentification Information			-	
For calendar plan year 2018 or fisc	cal plan year beginning 01/01/2018	and ending 12/31/2018	}		
A This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking this participating employer information in accorda			ns.)
	X a single-employer plan	a DFE (specify)			
B This return/report is:	the first return/report	the final return/report			
	an amended return/report	a short plan year return/report (less than 12 n	nonths))	
C If the plan is a collectively-barge	ained plan, check here			• [
D Check box if filing under:	Form 5558	automatic extension	the	e DFVC program	
	special extension (enter description	on)			
Part II Basic Plan Infor	mation—enter all requested informa	ation			
1a Name of plan KNIGHTS MECHANICAL WELFA			1b	Three-digit plan number (PN) ▶	501
			1c	Effective date of pla 01/01/2017	an
City or town, state or province	er, if for a single-employer plan) , apt., suite no. and street, or P.O. Bo , country, and ZIP or foreign postal co		2b	Employer Identifica Number (EIN) 62-1421625	tion
KNIGHTS MECHANICAL, LLC			2c	Plan Sponsor's tele number 270-765-4141	phone
4250 LEITCHFIELD ROAD CECILIA, KY 42724		ITCHFIELD RD ,, KY 42724-9642	2d	Business code (see instructions) 333200	e

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature. Signature of plan administrator	07/17/2019 Date	LORI BEGER Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature. Signature of employer/plan sponsor	07/17/2019 Date	LORI BEGER 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 Form 5500 (2018) Page **2**

3a	Plan administrator's name and address X Same as Plan Sponsor		3b Administrator's EIN
			3c Administrator's telephone number
4	If the name and/or EIN of the plan sponsor or the plan name has changed si	ince 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		
a c	Sponsor's name Plan Name		4d PN
5	Total number of participants at the beginning of the plan year	d (malfare also a secondate aghallana Os(4)	5 110
6	Number of participants as of the end of the plan year unless otherwise state 6a(2) , 6b , 6c , and 6d).	d (weitare plans complete only lines 6a(1),	
a(1) Total number of active participants at the beginning of the plan year		. 6a(1) 110
			100
a(2) Total number of active participants at the end of the plan year		. 6a(2) 126
b	Retired or separated participants receiving benefits		. 6b 0
С	Other retired or separated participants entitled to future benefits		. 6c 0
d	Subtotal. Add lines 6a(2) , 6b , and 6c		. 6d 126
е	Deceased participants whose beneficiaries are receiving or are entitled to re		. 6e
,			
T	Total. Add lines 6d and 6e		. 6f
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 wit		
	less than 100% vested		. 6h
7	Enter the total number of employers obligated to contribute to the plan (only If the plan provides pension benefits, enter the applicable pension feature co		. 7
	If the plan provides welfare benefits, enter the applicable welfare feature coc 4B 4D 4E 4Q		
9a	Plan funding arrangement (check all that apply) (1) Insurance	9b Plan benefit arrangement (check all th	at apply)
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) X Insurance Code section 412(e)(3)	insurance contracts
	(3) Trust	(3) Trust	
10	(4) X General assets of the sponsor	(4) X General assets of the s	<u>'</u>
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a		ber attached. (See Instructions)
а	Pension Schedules (4)	b General Schedules	motion)
	(1) R (Retirement Plan Information)	(1) H (Financial Inform	mation) nation – Small Plan)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(3) X 1 A (Insurance Info	,
	Purchase Plan Actuarial Information) - signed by the plan actuary	(4) C (Service Provid	•
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	` '	ing Plan Information)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		saction Schedules)
		<u>.</u> .	

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

SCHEDULE A (Form 5500)

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

2018

			ERISA section 103(a)(2).				rm is Open to Public Inspection
For calendar plan year 20	18 or fiscal pla	an year beginning 01/01/2018		and en	ding 12/31	1/2018	
A Name of plan KNIGHTS MECHANICAL	WELFARE B	ENEFIT PLAN		B Three	e-digit number (PN) •	501
C Plan sponsor's name a KNIGHTS MECHANICAL	, LLC			62-	1421625	ation Number	
		rning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		KENTUCKY				D. II	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered at policy or contract	end of	(f)	From	contract year (g) To
61-1311685	60219	766524	126	•	01/01/2018		12/31/2018
2 Insurance fee and com- descending order of the		nation. Enter the total fees and to	otal commissions paid. Lis	st in line 3	the agents, b	orokers, and	other persons in
(a) Total a	amount of com	nmissions paid		(b) To	otal amount o	of fees paid	
·		3578		•		•	144
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all p	persons).			
	(a) Name	and address of the agent, broke	er, or other person to whon	n commiss	ions or fees	were paid	
SHEPHERD INS DBA LLH			0 BLUEGRASS PKWY SVILLE, KY 40299				
(b) Amount of sales ar	nd hase	F	ees and other commission	s paid			
commissions pa		(c) Amount		d) Purpose	Э		(e) Organization code
	3578	144	BONUS				3
	(a) Name	and address of the agent, broke	er, or other person to whon	n commiss	ions or fees	were paid	
(b) Amount of sales ar	nd hase	F	ees and other commission	s paid			
commissions pa		(c) Amount		d) Purpose	9		(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				
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each car	rier may be treated as a unit	for purposes of
4	Curr	this report. ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year el			
6		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate account	s)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation guarantee		
		(3) guaranteed investment (4) other			
		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	b	Balance at the end of the previous year		7b	
	C	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)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			0
		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)		
		•			
		•			
				7./5\	
	£	(5) Total deductions		7e(5)	0
	T	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Pa	art II	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	group of employees of the ing purposes if such contr	racts are expe	erience-rated as a uni	t. Where co	ontracts cover individual
•	Dono	effit and contract type (check all applicable boxes)		iner may be	treated as a drift for pr	uiposes oi t	Tils Teport.
O		•	_	•	1		al Direct
	a [Health (other than dental or vision)	b X Dental		Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unem	ployment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract
	m 🛚	Other (specify) AD&D INSURANCE, VOL A	D&D INSURANCE, VOL I	LIFE INSURA	NCE		
	_	•					
9	Ехре	rience-rated contracts:					
	a P	Premiums: (1) Amount received		9a(1)			
	((2) Increase (decrease) in amount due but unpaid	J	9a(2)			
	((3) Increase (decrease) in unearned premium res	erve	9a(3)			
	((4) Earned ((1) + (2) - (3))				. 9a(4)	C
	b	Benefit charges (1) Claims paid					
	((2) Increase (decrease) in claim reserves		9b(2)		1	
		(3) Incurred claims (add (1) and (2))				. 9b(3)	С
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees	ľ	9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses	İ	9c(1)(D)			_
		(E) Taxes	ŀ	9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges				00/41/11	
		(H) Total retention	_			9c(1)(H)	1
		(2) Dividends or retroactive rate refunds. (These					
		Status of policyholder reserves at end of year: (1	•				
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves				9d(3)	
10		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	i in line 9c(2).	.)	. 9e	
10		nexperience-rated contracts:	an rriar			. 10a	20500
		Total premiums or subscription charges paid to c				. Iua	20566
		If the carrier, service, or other organization incurr retention of the contract or policy, other than repo- cify nature of costs.				. 10b	
Pa	art I	V Provision of Information					
11	Did	the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	X No
		ne answer to line 11 is "Yes," specify the informati					

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

Part I	Annual Report	dentification Informat	ion			
For caler	ndar plan year 2018 or fis	scal plan year beginning	01/01/2018	and endir	ng 12/31/2018	
A This r	return/report is for:	a multiemployer plan X a single-employer plan	participat	ing employer informa	s checking this box must attach a list of tion in accordance with the form instruction	ons.)
R This	return/report is:	the first return/report	the final i	eturn/report		
D 111131	eturi/report is.	an amended return/rep	oort a short p	an vear return/report	(less than 12 months)	
C If the	plan is a collectively-bar	gained plan, check here				
D Chec	k box if filing under:	Form 5558 special extension (enter	automatic description)	extension	the DFVC program	
Part II	Basic Plan Info	rmation—enter all requeste	ed information			
	ne of plan	L WELFARE BENEFIT	PLAN		1b Three-digit plan number (PN) ▶	501
			2 1 4 4 4		1c Effective date of p	olan
Mail	ing address (include room	yer, if for a single-employer pl m, apt., suite no. and street, o e, country, and ZIP or foreign	r P.O. Box)	instructions)	2b Employer Identific Number (EIN) 62-1421625	ation
	ights Mechanica				2c Plan Sponsor's te number 270-765-4141	lephone
425	50 Leitchfield	Road	4250 LEITCHFI	ELD RD	2d Business code (se instructions) 333200	ee
Ced	cilia	KY 42724	CECILIA	KY 42724	1-9642	
		or incomplete filing of this r				-1.1
Under pe	enalties of perjury and ot onts and attachments, as o	her penalties set forth in the ir well as the electronic version	of this return/report, and to	the best of my knowl	eturn/report, including accompanying sch edge and belief, it is true, correct, and co	mplete.
SIGN HERE	KinB	ease	07/17/20	LORI BEG	ER	
HEKE	Signature of plan adn	ninistrator	Date	Enter name of	f individual signing as plan administrator	
SIGN HERE	Km B	eese	07/17/20	LORI BEG	ER	
HERE	Signature of employe	r/plan sponsor	Date	Enter name of	f individual signing as employer or plan s	ponsor
SIGN HERE						
	Signature of DFE		Date	Enter name of	f individual signing as DFE	
F D	amusals Dadustian Ast I	latina and the Instructions	for Form FEOO		Form 550	10 (2018)

or Paperwork Reduction Act Notice, see the Instructions for Form 5500

v. 171027

	Form 5500 (2018)	rage Z	
3a	Plan administrator's name and address 🗓 Same as Plan Sponsor		3b Administrator's EIN
			3c Administrator's telephone number
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin enter the plan sponsor's name, EIN, the plan name and the plan number from	ace the last return/report filed for this plan,	4b EIN
a c	Sponsor's name Plan Name	The last returnineport.	4d PN
5	Total number of participants at the beginning of the plan year		5 110
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d).	(welfare plans complete only lines 6a(1),	
a(1) Total number of active participants at the beginning of the plan year		6a(1)
a(2) Total number of active participants at the end of the plan year	7 7 7 7	6a(2) 126
b	Retired or separated participants receiving benefits		6b
С	Other retired or separated participants entitled to future benefits		6c
d	Subtotal. Add lines 6a(2), 6b, and 6c.		
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	eive benefits.	6e
f	Total. Add lines 6d and 6e.		6f
g	Number of participants with account balances as of the end of the plan year (complete this item)	only defined contribution plans	6g
h	Number of participants who terminated employment during the plan year with less than 100% vested		6h
7	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 code of the plan provides welfare benefits, enter the applicable welfare feature code $4B-4D-4E-4Q$	es from the List of Plan Characteristics Cod	es in the instructions:
9a	Plan funding arrangement (check all that apply) (1)	9b Plan benefit arrangement (check all to the check all the check all to the check all	i) insurance contracts
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at		nber attached. (See instructions)
	Pension Schedules	b General Schedules	
		(1) H (Financial Info	rmation)
	(1) R (Retirement Plan Information)	(1)	illiation)
			rmation – Small Plan)
	 (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan 		rmation – Small Plan)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2) I (Financial Info	rmation – Small Plan) ormation)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(2) I (Financial Info (3) I A (Insurance Inf (4) C (Service Provi	rmation – Small Plan) ormation)

Form 5500 (2018)	Page 3
Part III Form M-1 Compliance Information (to	be completed by welfare benefit plans)
11a If the plan provides welfare benefits, was the plan subject	to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR
2520.101-2.)	No
If "Yes" is checked, complete lines 11b and 11c.	그는 그들은 나는 사람들은 사람들은 사람들이 되었다.
11b Is the plan currently in compliance with the Form M-1 filing	g requirements? (See instructions and 29 CFR 2520.101-2.)
11c Enter the Receipt Confirmation Code for the 2018 Form M	1-1 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 t Receipt Confirmation Code will subject the Form 5500 filing	that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid ag to rejection as incomplete.)
Receipt Confirmation Code	하다 그리고 말을 먹는데 그렇게 되는 것은 것이 없는 것이 없는 것이 없다.
Todalpt Gommutation Good	
	시 - 이 이렇게 이용하다 하다 하다가 보면 많은 이렇게 되었다.
	그는 어디를 하는 것으로 가능하는 사람이 되었다.
	그는 그 그리고 있는 그는 그를 가득하는 것이 되었다. 이렇게 되었다.
	그는 그들은 [20] 모든 그가는 그렇게 그렇게 됐었다면서 [20]
	그 그 그 그 그 그는 그는 그는 그를 잃었다. 그를 느껴서 하는 그리 없는 것
(1) 2 [1] 1	그는 그리다는 이 그 그렇게 된 이 그렇게 되지만 가나왔다.
	스 그리다 그는 그 그래 맛있는 병이를 되어 들었다.
요즘 회사 그 그리는 이 전 그 경기를 제하는 것	그것, 그들다 마시트를 중심한 걸리, 얼굴하는 데 나왔다. 어린
	그리아 이 그 나는 아이는 그리는 그리는 그래는 경찰 등이 하는 경험을 받는데
	그는 눈 없는 그리고 그 회의 계획 사용장이는 그를 유쾌한 경기를 받
	도 이 마음이 되고 하는 것도 살아왔다는 그렇게 되었다. 그렇게 되었다는 그런데
	어느 마음에 되는 이 그는 것이 되었다. 이 그 생각 사람들이 없는 것이다. 나를 다 없다.
	그 이 그 그는 그 그는 그는 그 가는 것 같은 사람들이 가지 않는 것 같아요.
	어제 그리 사람이 하는 사람들이 가능하고 많이 가셨다면서 봤어? 물리에게 다른
	이 그림 그림으로 있으로 가장하는 고리프라인하였다면 나는데 되었다.
	그 그의 시마요 보이 그 사람은 사람이 젖다면 가게 하는데 나다.
	그 그림 그는 그림 그림을 가는 것이 가끔하다고 있었다.
	보고 먹는 그는 사람들이 얼마나 하는 것이 하는데 얼마나 없다.
2 3, S Barrier Branch & British	그림 즐겁게 그렇게 그렇게 하겠습니다. 얼마나 있었다.
	불계 그리고 집 집 그리고 그렇게 젖혀가면서 깨끗하고 모든데 되었다.
12.12일 12.12일 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	그리아 보다 하다 그 시간 그렇게 가지 않는데 없는데 없었다.
	그리 날이 그 그 그 그는 그는 그는 그렇게 그는 아무를 그는 것이다.
	그는 그는 얼마나 그 바다 그 네그리겠습니다.
	그 그 그 그 이 그는 그 그 이 이 그 공연화관광 선지 않는 없다.
	그림으로 이 그는 그는 그를 잃고 있다면서 가는 것으로 다른다.
	그러그리다 그 그리고 하다 않고 됐다. 그런데 그림부터 그라고
	그는 얼마나 없는 살이 다른 수가 가면 가게 살아보니까 먹다고
[[[[[[[[[[[[[[[[[[[[[그 그는 그리다 사고 그는 경험 바다 전시에 가고 그 사람들이
맛이 말, 물건성 - "1. 레 라	그는 그들이 마음이다. 그는 이 시간이다고 있다고 있다면서 없는 것이다.
	그는 그 집에 다른 사람이 하면 되었다. 그렇게 되었다면 하는 사람들이 되었다면 하는데 되었다면 되었다면 되었다면 되었다면 되었다면 되었다면 되었다면 되었다면
	그 마이지는 그 물이 되고 있다는 이 바쁜 바다를 보다 했다.
	이번 그는 그리고 그리고 그 가능하는 그를 휴면되었다. 생생 내
	그는 그는 그는 그는 그들은 그들은 그 사람들은 내 경기를 받는다.
	강화하다. 이 나는 그렇지 이렇게 다 바로 이러워, 중편하는데, 그

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration 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

2018

Pension Benefit Guaranty Corporation Insurance companies are required to provide the information This Form is Open to Public pursuant to ERISA section 103(a)(2). 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 KNIGHTS MECHANICAL WELFARE BENEFIT PLAN 501 plan number (PN) C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN) 62-1421625 Knights Mechanical Llc Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract Part I on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier HUMANA INSURANCE COMPANY OF KENTUCKY Policy or contract year (e) Approximate number of (c) NAIC (d) Contract or (b) EIN persons covered at end of identification number code (f) From (g) To policy or contract year 766524 01/01/2018 61-1311685 60219 126 12/31/2018 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid. (b) Total amount of fees paid (a) Total amount of commissions paid 3,578 144 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Shepherd Ins dba LLH 11420 BLUEGRASS PKWY LOUISVILLE KY 40299 Fees and other commissions paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code Bonus 3,578 144 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (b) Amount of sales and base (c) Amount (d) Purpose (e) Organization code commissions paid

(a) Name a	and address of the agent, broker,	or other person to whom commissions or fees were paid	
(1)	F	ees and other commissions paid	(e) Organizatio
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	code
(a) Maria			
(a) Name a	and address of the agent, broker, o	or other person to whom commissions or fees were paid	
	- Fr	ees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organizatio code
(a) Name a	and address of the agent, broker,	or other person to whom commissions or fees were paid	
	i		
(h) Amount of color and have	F	ees and other commissions paid	(e) Organizatio
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	code
Management of the control of the con			
(a) Name a	and address of the agent, broker, o	or other person to whom commissions or fees were paid	
(a) Name a	and address of the agent, broker, o	or other person to whom commissions or fees were paid	
(a) Name a			
(b) Amount of sales and base	F	ees and other commissions paid	(e) Organizatio
			(e)
(b) Amount of sales and base	F	ees and other commissions paid	(e) Organizatio
(b) Amount of sales and base commissions paid	(c) Amount	ees and other commissions paid	(e) Organizatio code
(b) Amount of sales and base commissions paid	(c) Amount	ees and other commissions paid (d) Purpose	(e) Organizatio code
(b) Amount of sales and base commissions paid	(c) Amount	ees and other commissions paid (d) Purpose	(e) Organizatio code
(b) Amount of sales and base commissions paid (a) Name a	(c) Amount	ees and other commissions paid (d) Purpose	(e) Organizatio code
(b) Amount of sales and base commissions paid	(c) Amount	ees and other commissions paid (d) Purpose or other person to whom commissions or fees were paid	(e) Organizatio code
(b) Amount of sales and base commissions paid (a) Name a	(c) Amount	ees and other commissions paid (d) Purpose or other person to whom commissions or fees were paid ees and other commissions paid	(e) Organizatio code (e) Organizatio

_				
μ	a	0	P	-5

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	ridual contra	cts with each carrier may	be treated as	s a unit for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end		4	
110		rent value of plan's interest under this contract in separate accounts at year e			5	
6	Con	tracts With Allocated Funds:				New Action
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	Para la
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.	nnection wit	h the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre (3) other (specify)	d annuity			
Ť	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		ar dhalana
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in	separate accounts)	300	
	а	Type of contract: (1) deposit administration (2) mmedia (3) guaranteed investment (4) other		tion guarantee		
	b	Balance at the end of the previous year		1 1 1 1	7b	
	С	Additions: (1) Contributions deposited during the year			- 1.1.1.1.1	
		(2) Dividends and credits				
		(3) Interest credited during the year				
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		(6)Total additions		,	7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	0
	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)	0
		Delenge at the end of the current year (subtract line 7a/5) from line 7d/			7f	0

(s),
100
ct
0
0
0
7
100
,566
7000

Part IV	Provision of Information				
1 Did the	insurance company fail to provide any information necessary to complete Schedule A?	П	Yes	X No	

SUMMARY ANNUAL REPORT FOR KNIGHTS MECHANICAL WELFARE BENEFIT PLAN

This is a summary of the annual report of the KNIGHTS MECHANICAL WELFARE BENEFIT PLAN, a life insurance, dental and vision plan (Employer Identification Number 62-1421625, Plan Number 501), for the plan year 01/01/2018 through 12/31/2018. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has an insurance contract with HUMANA INSURANCE COMPANY OF KENTUCKY to pay certain Dental, Vision, Life insurance, AD&D INSURANCE, VOL AD&D INSURANCE, VOL LIFE INSURANCE claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2018 were \$20,566.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of LORI BEGER, who is a representative of the plan administrator, at 4250 Leitchfield Road, Cecilia, KY 42724 and phone number, 270-765-4141.

You also have the legally protected right to examine the annual report at the main office of the plan: 4250 Leitchfield Road, Cecilia, KY 42724, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.