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

	dentification Information				
For calendar plan year 2018 or fis	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 accordance)			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 m	onths))	
C If the plan is a collectively-barg	ained plan, check here			• [
D Check box if filing under:	Form 5558	automatic extension	the	e DFVC program	
	special extension (enter description	n)			
Part II Basic Plan Infor	mation—enter all requested information	on			
1a Name of plan SAMUEL A. RAMIREZ & CO. HE	1b	1b Three-digit plan number (PN) ▶ 501			
			1c	Effective date of plan 01/01/2016	
City or town, state or province	n, apt., suite no. and street, or P.O. Box) e, country, and ZIP or foreign postal code		2b	Employer Identifica Number (EIN) 13-2695511	tion
SAMUEL A. RAMIREZ & CO., INC			2c	Plan Sponsor's tele number 212-378-7198	phone
61 BROADWAY SUITE 2924 NEW YORK, NY 10006	2d	2d Business code (see instructions) 523120			

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	07/25/2019 Date	CHRISTINE LONG Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature. Signature of employer/plan sponsor	07/25/2019 Date	CHRISTINE LONG 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

							ninistrator's telephone nber
4 a	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 Sponsor's name				iled for this plan,	4b EIN	
С	Plan Name						
5	Total number of participants at the beginning of the plan year					5	141
6	Number of participants as of the end of the plan year unless otherwise states 6a(2), 6b, 6c, and 6d).	d (welfare p	ans cor	mplete	only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year					<u></u> 6a(1)	141
a(2) Total number of active participants at the end of the plan year					6a(2)	145
b	Retired or separated participants receiving benefits					6b	
С	Other retired or separated participants entitled to future benefits					6c	
d	Subtotal. Add lines 6a(2) , 6b , and 6c					6d	145
е	Deceased participants whose beneficiaries are receiving or are entitled to re-					_	
f	Total. Add lines 6d and 6e						145
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 b	enefits t	that we	re		
7	less than 100% vested						
_	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits.						
	Plan funding arrangement (check all that apply) (1)	(1) (2) (3) (4)	×	Insu Code Trus Gen	eral assets of the	3) insurance sponsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	ttached, an	d, where	e indica	ated, enter the nur	nber attach	ned. (See instructions)
а	Pension Schedules		eral Sc	hedule		uman attach	
	(1) R (Retirement Plan Information)	(1) (2)			H (Financial InfoI (Financial Info	,	Small Plan)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3)	X	7_	A (Insurance Inf		
	actuary	(4)	X		C (Service Prov	der Informa	ation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) (6)			D (DFE/Participation)G (Financial Trains)	ŭ	•

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).	inomatio	,,,,	Inis Fo	rm is Open to Public Inspection		
For calendar plan year 20	18 or fiscal pla	an year beginning 01/01/2018		and endi	ing 12/3	1/2018	•		
A Name of plan SAMUEL A. RAMIREZ &	CO. HEALTH	AND WELFARE BENEFITS PL		B Three- plan n	digit umber (PN) >	501		
C Plan sponsor's name a SAMUEL A. RAMIREZ &	(EIN)								
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.									
1 Coverage Information:									
(a) Name of insurance ca		MPANY OF AMERICA		di an af		Daliana			
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate num persons covered at e policy or contract y	end of	(f)	From	contract year (g) To		
13-5123390	64246	00483550	126		01/01/2018		12/31/2018		
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. List	in line 3 th	ne agents, t	orokers, and o	other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid									
3513 115							115		
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all pe	ersons).					
		and address of the agent, broke		commissio	ns or fees	were paid			
FNA INSURANCE SERVI	CES INC	FLOC	RIVER ROAD DR 2 MIT, NJ 07901						
(b) Amount of sales a	nd base	F	ees and other commissions	paid					
commissions pa		(c) Amount	(d) Purpose			(e) Organization code		
	3513	115					3		
	(a) Name	and address of the agent, broke	er, or other person to whom	commissio	ns or fees	were paid			
(b) Amount of sales a	nd base	<u> </u>	ees and other commissions	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)	(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	idual contracts v	vith each carrier may be	e treated as a	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	

Ρ	art III							
		If more than one contract covers the same of the information may be combined for reportion employees, the entire group of such individual.	ng purposes if such cont	racts are expe	erience-rated as a unit. V	Vhere cont	racts cover indi	
8	Benef	fit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b X Dental	с	Vision	d	Life insura	nce
	е 🗖	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemploy	yment h	Prescriptio	n drua
	: H	Stop loss (large deductible)	j HMO contract	· <u></u>	PPO contract		Indemnity of	•
	<u>'</u>		I I I I I I I I I I I I I I I I I I I	κ	FFO Contract	•	Indemnity (Jonitaci
	m	Other (specify)						
_		in an anatomic and an anatomic anatomic and an anatomic an						
9	•	rience-rated contracts:		00(1)				
		remiums: (1) Amount received						
	,	Increase (decrease) in amount due but unpaid Increase (decrease) in unearned premium rese						
		4) Earned ((1) + (2) - (3))				9a(4)		
	_ `	Benefit charges (1) Claims paid				34(4)		
		Increase (decrease) in claim reserves		(-)				
	,	3) Incurred claims (add (1) and (2))				9b(3)		
	•	4) Claims charged				9b(4)		
	,	Remainder of premium: (1) Retention charges (or						
		(A) Commissions	······	9c(1)(A)				
		(B) Administrative service or other fees		- (1)(-)				
		(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	_	_		c(1)(H)		
	((2) Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or 📗 d	credited.)	9c(2)		
	d s	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)		
40		Dividends or retroactive rate refunds due. (Do no	t include amount entered	d in line 9c(2) .)	9e		
10		experience-rated contracts:				10		
	_	Total premiums or subscription charges paid to ca				10a		11369
	r	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo ify nature of costs.	, .		·	10b		
	art IV							
11	Did t	the insurance company fail to provide any information	ation necessary to comp	lete Schedule	A? Ye	es X	No	
12	If the	e answer to line 11 is "Yes," specify the information	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

	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 SAMUEL A. RAMIREZ &	CO. HEALTH A	AND WELFARE BENEFITS PLAN		B Three	e-digit number (PN	N) •	501
C Plan sponsor's name a SAMUEL A. RAMIREZ &		e 2a of Form 5500			yer Identific 2695511	ation Number (EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca XCHANGE BENEFITS	rrier						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nun persons covered at (Policy or co	ontract year
(b) EIN	code	identification number	policy or contract y		(f)	From	(g) To
13-5459190	21113	US619513	270		01/01/2018	8	12/31/2018
2 Insurance fee and compute descending order of the		ation. Enter the total fees and total	commissions paid. List	t in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		53282					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all pe	ersons).			
		nd address of the agent, broker, o		commiss	ions or fees	were paid	
INTERNATIONAL BENEFI	TS ADMIN		RDEN CITY PLAZA N CITY, NY 11530				
(b) Amount of sales ar	nd base	Fees	and other commissions	s paid			
commissions pai	d	(c) Amount	(d	d) Purpose	9		(e) Organization code
	53282	0					3
	(a) Name a	nd address of the agent, broker, o	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	d	(c) Amount	(d	d) Purpose	9		(e) Organization code
	- A - (N - ()	and the leaders tions for Form FF	****			0-1	Iula A (Farm FEOO) 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		
(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

Part II		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 as a	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	

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same et the information may be combined for reporting purposes if such contracts are employees, the entire group of such individual contracts with each carrier may							acts are	expe	erience-rated as a unit	Where	contrac	ts cover individual	
8	Bene	efit a	nd contract type (check all applicable boxes)										
	а	a ☐ Health (other than dental or vision)							c 🗌	Vision		d	Life insurance
	е	Te	emporary disability (accident and sickness)	f	Lor	ng-term dis	abilit	y <u></u>	gΠ	Supplemental unemp	loyment	t h 🗌	Prescription drug
	i	_	op loss (large deductible)	ιĒ	_	O contract			k∏	PPO contract	•	ıΠ	Indemnity contract
	m	_	ther (specify)	, <u> </u>									,
	L	_ ر	inci (appeary)										
9	Expe	erieno	ce-rated contracts:										
	a F	rem	iums: (1) Amount received					9a(1)			4507	703	
		(2) lı	ncrease (decrease) in amount due but unpaid	b				9a(2)					
		(3) lı	ncrease (decrease) in unearned premium res	serve				9a(3)					
		(4) E	Earned ((1) + (2) - (3))				····- <u>-</u>				9a(4	1)	450703
	b	Ben	efit charges (1) Claims paid					9b(1)					
			ncrease (decrease) in claim reserves										
		(3) lı	ncurred claims (add (1) and (2))								9b(3	3)	
		` '	Claims charged								9b(4	1)	
	С	Ren	nainder of premium: (1) Retention charges (c	n an	accru	ıal basis) -	- ,		-				
			(A) Commissions				F	9c(1)(/					
			(B) Administrative service or other fees				Ī						
			(C) Other specific acquisition costs				Ī	9c(1)(0 9c(1)(0					
			(D) Other expenses				-	9c(1)(E	-				
			(E) Taxes(F) Charges for risks or other contingencies										
			(G) Other retention charges					9c(1)(0) })				
			(H) Total retention(H)								9c(1)	(H)	
			Dividends or retroactive rate refunds. (These			_			_		9c(2		
	d		rus 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			erience-rated contracts:							,			
	а	Tota	al premiums or subscription charges paid to o	arrier	r						10a	3	
	_	rete	e carrier, service, or other organization incur ntion of the contract or policy, other than rep- nature of costs.								10b)	
	art I		Provision of Information										_
11	Dic	the	insurance company fail to provide any inform	ation	nece	essary to c	omple	ete Sche	dule	A?	Yes	X N	0
12	If th	ne ar	nswer to line 11 is "Yes," specify the informat	ion no	ot pro	vided.							

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 For	m is Open to Public Inspection
For calendar plan year 20°	8 or fiscal plan	n year beginning 01/01/2018	and er	nding 12/31/2018	
A Name of plan SAMUEL A. RAMIREZ &	CO. HEALTH A	AND WELFARE BENEFITS PLAN		e-digit number (PN)	501
C Plan sponsor's name a SAMUEL A. RAMIREZ &		e 2a of Form 5500		oyer Identification Number (2695511	(EIN)
		rning Insurance Contract (Individual contracts grouped as			
1 Coverage Information:					
(a) Name of insurance car VISION SERVICE PLAN	rier				
/b) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	Policy or co	ontract year
(b) EIN	code	identification number	policy or contract year	(f) From	(g) To
22-2777159	47029	30018804	96	01/01/2018	12/31/2018
2 Insurance fee and common descending order of the		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers, and o	ther persons in
(a) Total a	mount of comr		(b) To	otal amount of fees paid	
		420			0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all persons).		
		and address of the agent, broker, o	or other person to whom commiss	sions or fees were paid	
MBL BENEFITS CONSULT	ING CORP	11TH FL	ST 39TH STREET OOR ORK, NY 10018		
(b) Amount of sales an	d base	Fees	and other commissions paid		
commissions pai		(c) Amount	(d) Purpos	e	(e) Organization code
	416	0			3
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	sions or fees were paid	
KINLOCH CONSULTING (ROUP INC	STE 260	/ILLE PARK RD LE, NY 11747		
(h) Amount of colors	d boos	Fees	and other commissions paid		
(b) Amount of sales an commissions pai		(c) Amount	(d) Purpos	e	(e) Organization code
	4	0	,, .1		3
For Panerwork Reduction	n Act Notice	see the Instructions for Form 55	500	School	dule A (Form 5500) 2018

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 as a	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 l	II	Welfare Benefit Contract Information if more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group	p of e	ses if s	such cor	ntracts are	е ехре	erience-rated as a u	nit. Where c	ontracts	s cover individual
8	Ben	efit a	and contract type (check all applicable boxes)										
	а	Не	ealth (other than dental or vision)	b	Dε	ental			CX	Vision		d	Life insurance
	е	Te	emporary disability (accident and sickness)	f 🗏	آ Lc	ona-terr	m disabi	litv	g	Supplemental une	mplovment	h∏	Prescription drug
	i F	=	op loss (large deductible)	ιĖ	_	MO cor		,		PPO contract	, ,		Indemnity contract
	L	_		, _	٦	WIO 001	muot			11 0 dominade		•П	macming contract
	m	_ 0	ther (specify)										
a	Evne	rion	ce-rated contracts:										
•	•		niums: (1) Amount received					9a(1)				
			ncrease (decrease) in amount due but unpaid										
			ncrease (decrease) in unearned premium res						-				
		` '	Earned ((1) + (2) - (3))								9a(4)		
		. ,	nefit charges (1) Claims paid								, ,		
		(2) I	ncrease (decrease) in claim reserves					9b(2)				
		(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 bas	sis)						
			(A) Commissions										
			(B) Administrative service or other fees					0 (4)					
			(C) Other specific acquisition costs					0 (4)					
			(D) Other expenses					0 - (4)					
			(E) Taxes										
			(F) Charges for risks or other contingencies.					0 - (4)					
			(G) Other retention charges(H) Total retention					L			9c(1)(H)	
			Dividends or retroactive rate refunds. (These			_			_				
	d		tus of policyholder reserves at end of year: (1			L							
	u		Claim reserves										
		` '	Other reserves										
	е	` '	dends or retroactive rate refunds due. (Do n										
10			perience-rated contracts:						()	,			
			al premiums or subscription charges paid to o	carrier	r						10a		1269
	b	If th	e carrier, service, or other organization incur- ention of the contract or policy, other than rep- nature of costs.	red ar	ny sp	pecific o	costs in	connection	on wit	h the acquisition or			
		cify r	nature of costs.	Dited		aiti, iii	ie Z abC	ve, repor	t amo	Juli			
	art I		Provision of Information							г	-		
11	Dic	the	insurance company fail to provide any inform	nation	ı nec	essary	to com	plete Sch	edule	A?	Yes	X No	
12	! If ti	ne ai	nswer to line 11 is "Yes," specify the informat	ion no	ot pro	ovided.	. •						

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	а	and ending 12/3	31/2018	
A Name of plan SAMUEL A. RAMIREZ &	CO. HEALTH A	AND WELFARE BENEFITS PLAN	В	Three-digit plan number (Pl	N) •	501
C Plan sponsor's name a SAMUEL A. RAMIREZ &		e 2a of Form 5500	D	Employer Identific 13-2695511	cation Number (EIN)
		ning Insurance Contract Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca		NY				
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number persons covered at end		Policy or co	ntract year
(b) EIN	code	identification number	policy or contract year		From	(g) To
13-1898173	64297	405074	122	01/01/201	8	12/31/2018
2 Insurance fee and coming descending order of the		ation. Enter the total fees and total	commissions paid. List in	line 3 the agents,	brokers, and ot	her persons in
(a) Total a	amount of comm			(b) Total amount	of fees paid	
		543				543
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all perso	ons).		
		nd address of the agent, broker, o	<u> </u>	mmissions or fees	were paid	
FNA INSURANCE SERVIC	CES INC		INYSIDE BLVD BURY, NY 11797			
(b) Amount of sales ar	nd base	Fees	and other commissions pa	id		
commissions pai	id	(c) Amount		urpose		(e) Organization code
	543	543 AD	DITIONAL COMPENSATIO	DN		3
	(a) Name a	nd address of the agent, broker, o	or other person to whom cor	mmissions or fees	were paid	
(b) Amount of sales ar	nd base	Fees	and other commissions pa	id		
commissions pai		(c) Amount	(d) Pi	urpose		(e) Organization code
For Bonominal Bodonia	n Ant Nation	and the Instructions for Form FF	***		0-1	Iula A (Farm FEOO) 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	
		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)	(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 as a	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 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 en	es if such	contr	acts are	expe	erience-rated as a unit	. Where	contrac	ts cover individual	
8	Bene	efit a	nd contract type (check all applicable boxes)											
	а	Не	ealth (other than dental or vision)	b	Den	ıtal			С	Vision		d	Life insurance	
	e >	₹ Te	emporary disability (accident and sickness)	f	Lon	g-term dis	ability	y	g	Supplemental unemp	loyment	h	Prescription drug	
	ιĒ	St	op loss (large deductible)	ı⊢	Тнмо	ocontract			- □ k □	PPO contract		ıĦ	Indemnity contract	
	m	_	ther (specify)	•	1							Ш	•	
	L		(4)											
9	Expe	erien	ce-rated contracts:											
	a F	rem	iums: (1) Amount received					9a(1)						
		(2) lı	ncrease (decrease) in amount due but unpaid	b				9a(2)						
		(3) lı	ncrease (decrease) in unearned premium res	serve .				9a(3)						
		. ,	Earned ((1) + (2) - (3))								9a(4)		
			efit charges (1) Claims paid				-							
			ncrease (decrease) in claim reserves											
		(3) lı	ncurred claims (add (1) and (2))								9b(3)		
		` '	Claims charged								9b(4)		_
	С		nainder of premium: (1) Retention charges (c			,	Г	5 (1)(1					
			(A) Commissions					9c(1)(/						
			(B) Administrative service or other fees					9c(1)(E						
			(C) Other specific acquisition costs				-	9c(1)([
			(D) Other expenses				-	9c(1)(E	-					
			(E) Taxes(F) Charges for risks or other contingencies				-							
			(G) Other retention charges				-	0-/4\//						
			(H) Total retention								9c(1)(H)		
			Dividends or retroactive rate refunds. (These						_		9c(2			
	d		us of policyholder reserves at end of year: (1								9d(1			
	٠.		Claim reserves								9d(2	•		_
		` '	Other reserves								9d(3	•		
	е	` '	dends or retroactive rate refunds due. (Do n								9e			
10			erience-rated contracts:							,				
	а	Tota	al premiums or subscription charges paid to o	carrier	·						10a		108	58
	_	rete	e carrier, service, or other organization incur ntion of the contract or policy, other than rep- nature of costs.								10b			
n	out 1	V	Provision of Information											
	art I													_
			insurance company fail to provide any inform			-	omple	ete Sche	dule	A?	Yes	X N	lo	
12	! If th	ne ar	nswer to line 11 is "Yes," specify the informat	ion no	t prov	vided.								

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 pla	n year beginning 01/01/2018	ar	nd ending 12/3	31/2018	
A Name of plan SAMUEL A. RAMIREZ &	CO. HEALTH	AND WELFARE BENEFITS PLAN		Three-digit plan number (P	PN)	501
C Plan sponsor's name a SAMUEL A. RAMIREZ &		e 2a of Form 5500	D E	mployer Identifi 13-2695511	cation Number (EIN)
		rning Insurance Contract L. Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca FIRST UNUM LIFE INSUR		ANY				
/L\ FINI	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or co	ontract year
(b) EIN	code	identification number) From	(g) To
13-1898173	64297	460242	145	01/01/201	18	12/31/2018
2 Insurance fee and communication 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 com		(b) Total amount	t of fees paid	
		5789				1739
3 Persons receiving com	missions and f	ees. (Complete as many entries a	s needed to report all persor	ns).		
	(a) Name a	and address of the agent, broker, o	or other person to whom com	missions or fees	s were paid	
FNA INSURANCE SERVIC	CES INC		INYSIDE BLVD BURY, NY 11797			
(b) Amount of sales ar	nd base	Fees	and other commissions paid	d		
commissions pai		(c) Amount	(d) Pu	•		(e) Organization code
	1739	1739 AD	DITIONAL COMPENSATION	N.		3
	(a) Name a	and address of the agent, broker, o	or other person to whom com	missions or fees	s were paid	
MBL BENEFITS CONSULT		323 WE: 11TH FL	ST 39TH STREET		,	
(b) Amount of sales ar	nd base	Fees	and other commissions paid	d		
commissions pai		(c) Amount	(d) Pu	rpose		(e) Organization code
	4050	0				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	
		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)	(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 as a	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 Inform									
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	ting p	urpo	ses if such cor	ntracts are	expe	erience-rated as a unit	. Where c	ontrac	ts cover individual
8	Benefit	and contract type (check all applicable boxes)									
	a∏⊦	Health (other than dental or vision)	b	De	ental		с	Vision		d X	Life insurance
	e ∏ -	Temporary disability (accident and sickness)	f	Lc	ong-term disabi	litv	gΠ	Supplemental unemp	olovment	h∏	Prescription drug
	- =	Stop loss (large deductible)	i E	_	MO contract	,		PPO contract	.,	ıĦ	Indemnity contract
		Other (specify) ACCIDENTAL DEATH AND	DISM				· ·	11 O contract		•□	macrimity contract
	^	Other (specify) PACCIDENTAL DEATH AND	DISIV	/ILIVI	DERIVIENT						
9	Evnorio	ence-rated contracts:									
•		emiums: (1) Amount received				9a(1	١ .				
) Increase (decrease) in amount due but unpair									
	` '	Increase (decrease) in unearned premium res									
) Earned ((1) + (2) - (3))							9a(4)		0
	_ ` '	enefit charges (1) Claims paid									
	(2)	Increase (decrease) in claim reserves				9b(2)				
	(3)	Incurred claims (add (1) and (2))							9b(3)		
	(4)	Claims charged							9b(4)		
	C Re	emainder of premium: (1) Retention charges (o	n an	accr	ual basis)						
		(A) Commissions									
		(B) Administrative service or other fees				_ ` ^ `					
		(C) Other specific acquisition costs									
		(D) Other expenses				0-/41/					
		(E) Taxes									
		(F) Other retention charges				A (4)(
		(G) Other retention charges(H) Total retention							9c(1)(H	1	
	(2)	Dividends or retroactive rate refunds. (These			_		_			'	
		tatus of policyholder reserves at end of year: (1					_		9c(2) 9d(1)		
		Claim reserves							9d(1)		
	` ') Other reserves							9d(3)		
	•	ividends or retroactive rate refunds due. (Do n							9e		
10		xperience-rated contracts:						,			
		otal premiums or subscription charges paid to o	carrier	r					10a		34773
	b If t	the carrier, service, or other organization incur	red ar	ny sı	pecific costs in	connectio	n with	n the acquisition or			
	re	tention of the contract or policy, other than rep		, ,				•	10b		
	Specify	y nature of costs.									
P	art IV	Provision of Information									
		ne insurance company fail to provide any inform	nation	nec	essary to com	olete Sche	edule	А?	Yes	X N	0
		answer to line 11 is "Yes," specify the informat									
. 2	n uic	and to the real specify the informati	.5.1 110	or bi	CVIGGG. F						

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

		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 SAMUEL A. RAMIREZ &	CO. HEALTH	AND WELFARE BENEFITS PL	AN		e-digit number (Pl	N) •	501
C Plan sponsor's name a		e 2a of Form 5500			•	ation Number (EIN)
SAMUEL A. RAMIREZ &	,				2695511		
		rning Insurance Contract. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca FIRST UNUM LIFE INSUR		ANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
13-1898173	64297	462193	36	i	01/01/2018	8	12/31/2018
2 Insurance fee and compute descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comi			(b) To	otal amount	of fees paid	
4705 1176							1176
3 Persons receiving com		ees. (Complete as many entrie					
		and address of the agent, broke		n commiss	ions or fees	were paid	
FNA INSURANCE SERVIC	DES INC		UNNYSIDE BLVD DBURY, NY 11797				
(b) Amount of sales ar	nd hase	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code
	1176	1176	ADDITIONAL COMPENS	ATION			3
	(a) Name a	and address of the agent, broke	r, or other person to whor	n commiss	ions or fees	were paid	
MBL BENEFITS CONSUL	MBL BENEFITS CONSULTING CORP 323 WEST 39TH STREET 11TH FLOOR NEW YORK, NY 10018						
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code
	3529	0					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	
		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)	(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 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		e same emplo	over(s) or members of t	the same er	mplovee organization	ons(s).
			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	ntracts cover indivi	\ //
8	Ben	efit a	and contract type (check all applicable boxes)						
	а	Н	ealth (other than dental or vision)	b Dental	С	Vision		d X Life insurance	е
	е	_ 	emporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemp	oloyment	h Prescription	drug
	i		top loss (large deductible)	j HMO contract	, 5 <u> </u>	PPO contract	,	I ☐ Indemnity co	_
	m		other (specify)	<i>-</i> L	<u> </u>	1		<u> </u>	
9	Ехр	erien	ce-rated contracts:						
	а	Pren	niums: (1) Amount received		9a(1)				
		(2)	ncrease (decrease) in amount due but unpaid	d	9a(2)				
			ncrease (decrease) in unearned premium res	· ·					
		(4)	Earned ((1) + (2) - (3))				9a(4)		
	b	Ber	nefit charges (1) Claims paid		` '				
		(2)	ncrease (decrease) in claim reserves		9b(2)				
		(3)	ncurred claims (add (1) and (2))				9b(3)		
		` '	Claims charged				9b(4)		
	С	Rei	mainder of premium: (1) Retention charges (n an accrual basis)					
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees		9c(1)(B)				
			(C) Other specific acquisition costs		9c(1)(C)				
			(D) Other expenses		9c(1)(D)				
			(E) Taxes		9c(1)(E) 9c(1)(F)				
			(F) Charges for risks or other contingencies.						
			(G) Other retention charges	· ·	l l		9c(1)(H)		
		(0)	(H) Total retention	_	_				
	-1		Dividends or retroactive rate refunds. (These	_			9c(2)		
	d		tus of policyholder reserves at end of year: (1				9d(1)		
		. ,	Claim reserves				9d(2)		
	_	` '	Other reserves				9d(3) 9e		
10	e No		idends or retroactive rate refunds due. (Do no perience-rated contracts:	ot include amount entered	i iii iiiie 90(2).	.)	36		
10	a		al premiums or subscription charges paid to o	earrier			10a		23524
			, , ,				100		23324
	b Spe	rete	ne carrier, service, or other organization incurention of the contract or policy, other than rep nature of costs.				10b		
	Spe	ы	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	А?	Yes	X No	
			nswer to line 11 is "Yes," specify the informat		-				
			• • •	·					

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

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 SAMUEL A. RAMIREZ &	CO. HEALTH	AND WELFARE BENEFITS PL	AN	B Three plan	e-digit number (PN	N) •	501
C Plan sponsor's name a SAMUEL A. RAMIREZ & 0		e 2a of Form 5500			yer Identific 2695511	ation Number (EIN)
		rning Insurance Contract. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance car UNUM LIFE INSURANCE		FAMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
01-0278678	62235	410108	1		01/01/2018	8	12/31/2018
2 Insurance fee and common descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of com	missions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broke	r, or other person to whor	m commiss	ions or fees	were paid	
(b) Amount of sales an	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code
	(a) Name a	and address of the agent, broke	r, or other person to whor	m commissi	ions or fees	were paid	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(b) Amount of sales an	(b) Amount of sales and base Fees and other commissions paid						
commissions pai		(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	
		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

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 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	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	group of employees of thing purposes if such con	tracts are expe	erience-rated as a unit	. Where co	ontracts cover individual	
8	Benef	fit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	е ⊟	1	f Long-term disabil	ity g	Supplemental unemp	olovment	h Prescription drug	
	iΠ		j HMO contract	· - <u>-</u>	PPO contract		- -	
	닏	Stop loss (large deductible)	I HIVIO CONTIACT	ν_	PPO COMITACI		I Indemnity contract	
	m X	Other (specify) MISCELLANEOUS						
0		rianae rated contractor						
J	•	rience-rated contracts: remiums: (1) Amount received		9a(1)			_	
		2) Increase (decrease) in amount due but unpaid					_	
		3) Increase (decrease) in unearned premium rese					_	
	,	(4) Earned ((1) + (2) - (3))				9a(4)		- 0
	,	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))				9b(3)		C
	(4	4) Claims charged				9b(4)		
	C F	Remainder of premium: (1) Retention charges (or	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees						
		(C) Other specific acquisition costs		- 4.114-1				
		(D) Other expenses		0-/4\/5\				
		(E) Taxes					_	
		(F) Charges for risks or other contingencies		9C(1)(F)				
		(G) Other retention charges				0c/1\/L	Λ .	
	,	(A) Dividende or retroetive rate refunde. (These	_	_		9c(1)(H)	<i>,</i>	
		(2) Dividends or retroactive rate refunds. (These						
		Status of policyholder reserves at end of year: (1)						
	,	(2) Claim reserves(3) Other reserves				9d(2) 9d(3)		_
	,	Dividends or retroactive rate refunds due. (Do no					_	_
10		nexperience-rated contracts:	i molado amodrit critoro	a III IIII 0 00(2).	.,			
		Total premiums or subscription charges paid to ca	arrier			10a		361
	b 1	If the carrier, service, or other organization incurre retention of the contract or policy, other than repoilty nature of costs.	ed any specific costs in o	connection with	h the acquisition or	10b		
P	r	retention of the contract or policy, other than repo				10b		
		the insurance company fail to provide any informa	ation necessary to comp	lata Schadula	Δ2 Π	Yes	X No	_
				iete Scheaule	A:	1 69	NO NO	_
12	If the	e answer to line 11 is "Yes," specify the information	on not provided. •					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Service Provider 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

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
SAMUEL A. RAMIREZ & CO. HEALTH AND WELFARE BENEFITS PLAN	plan number (PN) 501
	plan number (FN)
Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
SAMUEL A. RAMIREZ & CO., INC.	13-2695511
SAMOLE ALTA WHITE LA CO., INC.	13-2695511
Double Comics Drawider Information (see instructions)	
Part I Service Provider Information (see instructions)	
Now word associated this Double association as with the Section Constitution of the Section of	wind for and the same with a second discoult and in the same of the OF 000
You must complete this Part, in accordance with the instructions, to report the information req or more in total compensation (i.e., money or anything else of monetary value) in connection value.	
plan during the plan year. If a person received only eligible indirect compensation for which t	
answer line 1 but are not required to include that person when completing the remainder of the	
1 Information on Persons Receiving Only Eligible Indirect Compensation	on
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this	
indirect compensation for which the plan received the required disclosures (see instructions for	
multiest compensation for which the plan received the required disclosures (see instructions to	definitions and conditions)
b If you answered line 1a "Yes," enter the name and EIN or address of each person providing	the required disclosures for the service providers who
received only eligible indirect compensation. Complete as many entries as needed (see instru	·
(
(b) Enter name and EIN or address of person who provided you discl	osures on eligible indirect compensation
(-)	
(b) Enter name and EIN or address of person who provided you discl	locures on eligible indirect componenties
(b) Enter name and Envior address of person who provided you discr	osures on eligible indirect compensation
(b) Enter name and EIN or address of narron who provided you disa	legures on cligible indirect companyation
(b) Enter name and EIN or address of person who provided you discl	osures on eligible indirect compensation
/b>	
(b) Enter name and EIN or address of person who provided you discl	osures 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				
2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).								
		((a) Enter name and EIN or	r address (see instructions)				
INTERNAT	TIONAL BENEFITS AL	DMINISTRATO		RDEN CITY PLAZA EN CITY, NY 11530				
11-329316	2							
(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	CLAIMS PROCESSOR	28124	Yes No 🛚	Yes No 🗵	0	Yes No X		
		(a) Enter name and EIN or	address (see instructions)				
MBL BENE 20-293041	EFITS CONSULTING	CORP	11TH F	EST 39TH STREET LOOR ORK, NY 10018				
(b) Service Code(s)	Relationship to employer, employer 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?		
22 53 70	INDEPENDENT BROKER	77337	Yes No 🛚	Yes No 🗵	0	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	(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

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 the 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	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of 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	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of 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	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.		

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

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Pa	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.	
Ex	planation	γ:		
а	Name:		b EIN:	
С	Positio			
d	Addres		e Telephone:	
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Ex	planation	n:		
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С	Positio			
d	Addres	SS:	e Telephone:	
EX	planation):		
	Mana		b EIN:	
a C	Name: Position		D EIN:	
d	Addres		e Telephone:	
u	Addres	5.	• тетернопе.	
Ex	Explanation:			
а	Name:		b EIN:	
С	Positio	n:		
d	Addres		e Telephone:	
-				
Explanation:				