Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2018

Pensio	n Benefit Guaranty Corporation	-			This	Form is Open to Pu Inspection	ıblic	
Part I	Annual Report Ide	entification Information				-		
For caler		I plan year beginning 06/01/2018		and ending 05/31/20	019		-	
A This	return/report is for:	a multiemployer plan		loyer plan (Filers checking t			ns.)	
		X a single-employer plan	a DFE (specify)					
B This return/report is:								
		an amended return/report	a short plan yea	ar return/report (less than 1	2 months))		
C If the	plan is a collectively-bargai	ned plan, check here				• [
D Chec	k box if filing under:	Form 5558	automatic exten	sion	the	e DFVC program		
		special extension (enter description)						
Part II	Basic Plan Inform	ation—enter all requested informatio	n					
	ne of plan JTO COMPANY, INC EMPL				1b	Three-digit plan number (PN) ▶	501	
	,				1c	1c Effective date of plan 06/01/2016		
Mail City	ing address (include room, a or town, state or province, c	, if for a single-employer plan) apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code	(if foreign, see instru	uctions)	2b	2b Employer Identification Number (EIN) 65-0535840		
KIRK AU	TO COMPANY, INC				2c	2c Plan Sponsor's telephone number 662-226-3632		
	FRONTAGE RD A, MS 38901-8009		ONTAGE RD , MS 38901-8009	2d Business code (see instructions) 441110				
Caution	A penalty for the late or i	ncomplete filing of this return/repor	t will be assessed u	ınless reasonable cause i	s establis	shed.		
		penalties set forth in the instructions, I as the electronic version of this return						
_								
SIGN HERE	Filed with authorized/valid	electronic signature.	07/31/2019	DEBORAH J ADAMS				
IILIVL	Signature of plan admini	istrator	Date	Enter name of individual s	igning as	plan administrator		

Date

Date

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

Signature of employer/plan sponsor

Signature of DFE

SIGN HERE

SIGN HERE

> Form 5500 (2018) v. 171027

Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

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 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: 4d PN Sponsor's name Plan Name Total number of participants at the beginning of the plan year 226 5 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 226 a(1) Total number of active participants at the beginning of the plan year 6a(1) 233 a(2) Total number of active participants at the end of the plan year 6a(2)0 Retired or separated participants receiving benefits.... 6b 0 Other retired or separated participants entitled to future benefits...... 6c 233 6d Subtotal. Add lines 6a(2), 6b, and 6c. Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e 0 233 Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 0 6g complete this item) Number of participants who terminated employment during the plan year with accrued benefits that were 0 less than 100% vested 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)...... 7 If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: **b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

9a	Plan fun	ding arrangement (cneck all that apply)	90	Plan bene	e iir	irrangement (cneck all that apply)
	(1)	X Insurance		(1)	X	Insurance
	(2)	Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts
	(3)	Trust		(3)		Trust
	(4)	General assets of the sponsor		(4)		General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

а

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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).		1011	Inis Foi	m is Open to Public Inspection
For calendar plan year 20	18 or fiscal pla	an year beginning 06/01/2018		and en	ding 05/31	/2019	
A Name of plan KIRK AUTO COMPANY, INC EMPLOYEE BENEFITS PLAN					e-digit number (PN)	•	501
C Plan sponsor's name as shown on line 2a of Form 5500 KIRK AUTO COMPANY, INC D Employer Identification Number (EIN 65-0535840							(EIN)
		erning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca BLUE CROSS BLUE SHIE		NC.					
/h) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f) F	rom	(g) To
64-0295748	60111	0034328	233		06/01/2018		05/31/2019
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	rokers, and o	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		32024					0
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all p	ersons).			
	(a) Name	and address of the agent, broke	er, or other person to whom	n commissi	ions or fees w	vere paid	
MICHELLE BRANSCOME							
(b) Amount of sales ar	nd base	Fe	ees and other commission	s paid			
commissions pa		(c) Amount		d) Purpose	9		(e) Organization code
	32024						3
	(a) Name	and address of the agent, broke	er, or other person to whom	commissi	ions or fees w	vere paid	
	(a) Hamo	and address of the agont, protes	, or early porcent e whom		10110 01 1000 1	voro para	
(b) Amount of sales ar	nd base	Fe	ees and other commission	s paid			
commissions pa		(c) Amount	(d) Purpose	e		(e) Organization code

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

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of						
		this report.						
		ent value of plan's interest under this contract in the general account at year			4			
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5			
6		racts With Allocated Funds:						
	а	State the basis of premium rates						
	b	Premiums paid to carrier			6b			
	C	Premiums due but unpaid at the end of the year			6c			
	d	If the carrier, service, or other organization incurred any specific costs in co			6d			
		retention of the contract or policy, enter amount.			-			
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
				_				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin						
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)				
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee				
		(3) ☐ guaranteed investment (4) ☐ other ▶						
		-						
	b	Balance at the end of the previous year			7b			
	С	Additions: (1) Contributions deposited during the year						
		(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	. 7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	. 7c(5)					
		•						
	_	(6)Total additions			7c(6)			
		Total of balance and additions (add lines 7b and 7c(6))			7d			
		Deductions:	7-(4)					
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		(2) Administration charge made by carrier	7e(2)					
		(3) Transferred to separate account	7e(3) 7e(4)					
		(4) Other (specify below)	. /e(4)					
		•						
		(5) Total deductions			7e(5)			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f			

Р	art	III Welfare Benefit Contract Informa	ation				
		If more than one contract covers the same of the information may be combined for report					
		employees, the entire group of such individu					
8	Ben	efit and contract type (check all applicable boxes)					
	а	X Health (other than dental or vision)	b Dental	с	Vision	d	Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g \Box	Supplemental unemployme	nt h 🔀	Prescription drug
	i İ	Stop loss (large deductible)	j HMO contract	· - <u>-</u>	PPO contract	ıĖ	Indemnity contract
	m	Other (specify)			11 0 contract		I madminity deminate
	••••	Other (specify)					
_	_						
9		erience-rated contracts:		0-(4)	74	1407	
	а	Premiums: (1) Amount received		9a(1)	/14	1487	
		(2) Increase (decrease) in amount due but unpaid		9a(2) 9a(3)		0	
		(3) Increase (decrease) in unearned premium res (4) Earned ((1) + (2) - (3))		` ' '	9a	(A)	714487
	b	Benefit charges (1) Claims paid	i			3256	7 14407
	D	(2) Increase (decrease) in claim reserves				5256	
		(3) Incurred claims (add (1) and (2))					588512
		(4) Claims charged					1523347
	С	Remainder of premium: (1) Retention charges (o		•••••		,	
	•	(A) Commissions	,	9c(1)(A)	32	2024	
		(B) Administrative service or other fees				0731	
		(C) Other specific acquisition costs		9c(1)(C)	_		
		(D) Other expenses		0 (4)(D)			
		(E) Taxes		9c(1)(E)	10)717	
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention			9c(1)(H)	103472
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	oredited.)9c	(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement 9d	(1)	
		(2) Claim reserves			9d	(2)	
		(3) Other reserves			9d	(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	l in line 9c(2).)9	е	
10	No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier		10	а	
	b	If the carrier, service, or other organization incurr					
	Cne	retention of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	unt 10	b	
	Spe	ecify nature of costs.					
P	art	IV Provision of Information					
			otion noongon, to accept	oto Cobodul-	A? \(\text{ Yes} \)	X	
		d the insurance company fail to provide any inform		ete Schedule	A: I tes	^ N	No
12	lf t	the answer to line 11 is "Yes," specify the informati	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 p	olan year 20°	18 or fiscal pl	an year beginning 06/01/2018		and en	ding 05/3	31/2019		
A Name of pl	an COMPANY, I	INC EMPLOY	EE BENEFITS PLAN			e-digit number (PI	N) •	501	
C Plan spons			ne 2a of Form 5500			oyer Identific 0535840	ation Number (EIN)	
Part I			erning Insurance Contract A. Individual contracts grouped as						
1 Coverage I	nformation:								
(a) Name of in			NY						
<i>a</i>		(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year	
(b) E	IN	code	identification number	persons covered at policy or contract		(f)	From	(g) To	
94-2761537		81396	49768	138		06/01/2018	8	05/31/2019	
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.									
	(a) Total amount of commissions paid (b) Total amount of fees paid								
	7136								
3 Persons re	ceiving com	missions and	fees. (Complete as many entries	as needed to report all p	persons).				
		(a) Name	and address of the agent, broker,	or other person to whon	n commiss	ions or fees	were paid		
MWL				DX 14067 ON, MS 39236					
(b) Amoun	it of sales an	nd base	Fee	s and other commissior	ns paid				
	missions pai		(c) Amount			(e) Organization code			
2810				3					
		(a) Name	and address of the agent, broker,	or other person to whom	n commiss	ions or fees	were paid		
MICHELLE BR	ANSCOME	· · ·	P.O. BC	OX 1531 DA, MS 38902			·		
(b) Amoun	nt of sales an	nd hase	Fee	s and other commission	ns paid				
	missions pai		(c) Amount		(d) Purpos	e		(e) Organization code	
		4326						3	
F D	de Dadrestia	n Act Natice	oce the Instructions for Form F	E00			Caba	lula A (Farm FEOO) 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	(0,1	(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.			-			
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
				_				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin						
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)				
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee				
		(3) ☐ guaranteed investment (4) ☐ other ▶						
		-						
	b	Balance at the end of the previous year			7b			
	С	Additions: (1) Contributions deposited during the year						
		(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	. 7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	. 7c(5)					
		•						
	_	(6)Total additions			7c(6)			
		Total of balance and additions (add lines 7b and 7c(6))			7d			
		Deductions:	7-(4)					
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		(2) Administration charge made by carrier	7e(2)					
		(3) Transferred to separate account	7e(3) 7e(4)					
		(4) Other (specify below)	. /e(4)					
		•						
		(5) Total deductions			7e(5)			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f			

Ρ	art III							
		If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	ng purposes if such cont	racts are expe	erience-rated as a unit.	Where cor	ntracts	cover individual
8	Benef	fit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b X Dental	С	Vision		d∏ι	_ife insurance
	е 🗍	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	lovment	h∏ı	Prescription drug
	iΗ	Stop loss (large deductible)	j HMO contract		PPO contract	,	브	ndemnity contract
	. H) [] Tilvio contract	· L	110 contract		.⊓.	identifity contract
	m 📗	Other (specify)						
9	Evnori	ience-rated contracts:						
9	•	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)	-	
	- '	Benefit charges (1) Claims paid			•			
	(2	2) Increase (decrease) in claim reserves		9b(2)				
	(3	3) Incurred claims (add (1) and (2))				9b(3)		
	(4	4) Claims charged				9b(4)		
	C F	Remainder of premium: (1) Retention charges (or	n an accrual basis)					
		(A) Commissions					4	
		(B) Administrative service or other fees		0 (4)(0)			_	
		(C) Other specific acquisition costs					_	
		(D) Other expenses		0-(4)(5)			4	
		(E) Taxes(F) Charges for risks or other contingencies					-	
		(G) Other retention charges		0 (4)(0)			-	
		(H) Total retention				9c(1)(H)	+	
	C	(2) Dividends or retroactive rate refunds. (These	_	_	F	9c(2)	+	
		Status of policyholder reserves at end of year: (1)		_	l l	9d(1)	+	
		(2) Claim reserves	•		F	9d(2)	+	
	,	(3) Other reserves			F	9d(3)	+	
	,	Dividends or retroactive rate refunds due. (Do no				9e		
10	None	experience-rated contracts:			_			
	a T	Total premiums or subscription charges paid to ca	arrier			10a		43257
	r	f the carrier, service, or other organization incurre retention of the contract or policy, other than repo	, ,		•	10b		
	Speci	ify nature of costs.						
	art IV		otion nonogen to see	loto Colt - dul -	A2	Ves	X No	
		the insurance company fail to provide any informa		iete Schedule	A?	Yes	× 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

pursuant to ERISA section 103(a)(2).			111151	Inspection			
For calendar plan year 20	18 or fiscal pla	n year beginning 06/01/2018	and er	nding 05/31/2019			
A Name of plan KIRK AUTO COMPANY, INC EMPLOYEE BENEFITS PLAN				ee-digit n number (PN)	501		
C Plan sponsor's name a KIRK AUTO COMPANY,		e 2a of Form 5500		oyer Identification Numb -0535840	er (EIN)		
		rning Insurance Contract (Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
41 \ FIN	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy of	r contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To		
06-1222784	39616	19768	118	06/01/2018	05/31/2019		
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.							
(a) Total a	amount of com		(b) Total amount of fees paid				
		2412					
3 Persons receiving com	missions and fo	ees. (Complete as many entries a	s needed to report all persons).				
	(a) Name a	and address of the agent, broker, o	•	sions or fees were paid			
MWL		P.O. BO JACKSC	X 14067 N, MS 39236				
(b) Amount of sales ar	nd base	Fees	and other commissions paid				
commissions pa	id	(c) Amount	(d) Purpos	(e) Organization code			
1261					3		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
MICHELLE BRANSCOME		P.O. BO					
(b) Amount of sales ar	nd hase	Fees	and other commissions paid				
commissions pa		(c) Amount	(d) Purpose		(e) Organization code		
	1151				3		
For Bonomical Bodonii	n Act Natice	and the Instructions for Form FF	200	0-	hadula A /Farm FEOO) 2019		

Schedule A (Form 5500	Schedule A (Form 5500) 2018 Page 2 – 1					
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
			(5)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
	T					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
, ,						
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
·						
(a) Na						
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization			
commissions paid	(0)	(4) - 3-1-2-3	code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
	T					
	•	Fees and other commissions paid				
(b) Amount of sales and base		·	(e) Organization			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
		·	Organization			

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts v	vith each carrier may be	e treated a	as a unit for purposes of
		this report.				
	Curre	4				
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount.			-	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		-				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:	7-(4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3) 7e(4)			
		(4) Other (specify below)	. /e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Pa	art	Ш	Welfare Benefit Contract Inform	ation				
			If more than one contract covers the same the information may be combined for repor					
			employees, the entire group of such individ					
8	Ben	efit aı	nd contract type (check all applicable boxes)			,		
•	a [_	alth (other than dental or vision)	b Dental	c X	Vision		d Life insurance
	u [e [- 📙	<u> </u>	Supplemental unem	nlovmont	h Prescription drug
	. [_	mporary disability (accident and sickness)		- =	1 -	pioyment	<u> </u>
	ן י	_	op loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity contract
	m	Ot	her (specify)					
_								
			e-rated contracts:	!	2 (1)			
	а		iums: (1) Amount received		9a(1)			
			ncrease (decrease) in amount due but unpaid		9a(2) 9a(3)			
			ncrease (decrease) in unearned premium restarned ((1) + (2) - (3))	•			. 9a(4)	
	b	. ,	efit charges (1) Claims paid				. 3a(+)	
	~		ncrease (decrease) in claim reserves					
		` '	ncurred claims (add (1) and (2))		. ,		. 9b(3)	
			laims charged				9b(4)	
	С	` '	nainder of premium: (1) Retention charges (
		((A) Commissions		9c(1)(A)			
		((B) Administrative service or other fees		9c(1)(B)			
		((C) Other specific acquisition costs					
			(D) Other expenses					
		((E) Taxes		9c(1)(E)			
		((F) Charges for risks or other contingencies.		9c(1)(F)			
			(G) Other retention charges				0 - (4)(11)	
			(H) Total retention				9c(1)(H))
			Dividends or retroactive rate refunds. (These	_			• • •	
	d		us of policyholder reserves at end of year: (1					
		` '	Claim reserves				9d(2)	
	е	` '	Other reservesdends or retroactive rate refunds due. (Do n				. 9d(3) . 9e	
10	_		erience-rated contracts:	5t include amount entered	in inie 30(2)	.)	. 30	
. •	a		Il premiums or subscription charges paid to o	arrier			. 10a	11483
	b		e carrier, service, or other organization incur				100	
	~		ntion of the contract or policy, other than rep	, ,			. 10b	
	Spe	cify n	ature of costs.					
D-	art	IV	Provision of Information					
						🗆	Va-	₩ Na
			insurance company fail to provide any inforn		ete Schedule	A?	Yes	X No
12	If t	he an	swer to line 11 is "Yes," specify the informat	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

Pension Bene	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Fo	rm is Open to Public Inspection				
For calendar plan year 2018 or fiscal plan year beginning 06/01/2018				and	d ending 05/3	31/2019			
A Name of plan KIRK AUTO COMPANY, INC EMPLOYEE BENEFITS PLAN			/EE BENEFITS PLAN			hree-digit blan number (Pl	N) •	501	
C Plan spons KIRK AUTO C			ne 2a of Form 5500		D Er	nployer Identific 65-0535840	cation Number	(EIN)	
Part I			erning Insurance Contract A. Individual contracts grouped a						
1 Coverage Ir	formation:								
(a) Name of in			OMPANY			,	Delivere		
(b) El	N	(c) NAIC code	(d) Contract or identification number	(e) Approximate not persons covered a policy or contract	at end o	f	From	(g) To	
73-0714500		60410	KIRK	120	-	06/01/201	8	05/31/2019	
		mission inforr amount paid	mation. Enter the total fees and to	tal commissions paid. L	ist in lin	e 3 the agents,	brokers, and	other persons in	
			nmissions paid		(b) Total amount	of fees paid		
			4484					136	
3 Persons red	ceiving com	missions and	fees. (Complete as many entries	s as needed to report all	person	s).			
			and address of the agent, broker				were paid		
MS AUTOMOB	ILE DEALE	RS ASSOC		/OODLANDS PRKKWY ELAND, MS 39157	STE 20	0			
(b) Amoun	t of sales ar	nd base	Fe	es and other commission	ns paid				
commissions paid		(c) Amount		(d) Purpose		(e) Organization code			
		136 FEES		3					
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid									
SECURITY ALL	EGIANCE	CORPORAT	ION P.O. E GREN	3OX 1531 IADA, MS 38902					
(b) Amoun	t of sales ar	nd base	Fe	es and other commission	ns paid				
` '	nissions pai		(c) Amount		(d) Pur	pose		(e) Organization code	
		4484						3	
For Donor	l. Dadwatia	n Act Notice	ass the Instructions for Form	EE00			Cala		

Schedule A (Form 5500	Schedule A (Form 5500) 2018 Page 2 – 1					
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
			(5)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
	T					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
, ,						
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
·						
(a) Na						
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization			
commissions paid	(0)	(4) - 3-1-2-3	code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
	T					
	•	Fees and other commissions paid				
(b) Amount of sales and base		·	(e) Organization			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
		·	Organization			

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts v	vith each carrier may be	e treated a	as a unit for purposes of
		this report.				
	Curre	4				
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount.			-	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		-				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:	7-(4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3) 7e(4)			
		(4) Other (specify below)	. /e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Pa	art	Ш	Welfare Benefit Contract Informa	ation					
			If more than one contract covers the same						
			the information may be combined for report employees, the entire group of such individ						
Ω	Don	ofit o	nd contract type (check all applicable boxes)		arrier may be	troated do a drift for p	uiposco oi i	ппо торота	_
O	Г			. —		1		al [
	a [_	ealth (other than dental or vision)	b Dental	_	Vision		d X Life insurance	
	е	X Te	emporary disability (accident and sickness)	f X Long-term disability	ty g	Supplemental unem	ployment	h Prescription drug	
	i	St	op loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m	O	ther (specify)						
	L								
9	Ехре	erien	ce-rated contracts:						
			niums: (1) Amount received		9a(1)				
		(2) li	ncrease (decrease) in amount due but unpaid	b					
		(3) li	ncrease (decrease) in unearned premium res	serve	9a(3)				
		(4) E	Earned ((1) + (2) - (3))				. 9a(4)		
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) lı	ncrease (decrease) in claim reserves		9b(2)				
		(3) li	ncurred claims (add (1) and (2))				. 9b(3)		
		` '	Claims charged				. 9b(4)		_
	С	Ren	nainder of premium: (1) Retention charges (c	n an accrual basis)					
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees						
			(C) Other specific acquisition costs						
			(D) Other expenses						
			(E) Taxes		9C(1)(E)				
			(F) Charges for risks or other contingencies.		9C(1)(F)			_	
			(G) Other retention charges				0-(4)(11)	١	
			(H) Total retention				9c(1)(H))	
			Dividends or retroactive rate refunds. (These	—					
	d		tus of policyholder reserves at end of year: (1						
		` '	Claim reserves				9d(2)		
	_	` '	Other reserves				. 9d(3)		
10	<u>e</u>		dends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2)	.)	. 9e		_
10	_		perience-rated contracts:	20 44 4			100	202	70
	a		al premiums or subscription charges paid to c				. 10a	303	70
	b		e carrier, service, or other organization incur- ntion of the contract or policy, other than rep	, ,		•	. 10b		
	Spe		nature of costs.	sited in Fait 1, into 2 abov	o, roport arrio	, unit			
P	art	IV	Provision of Information						_
				nation nocessarity assess	loto Cobe dul-	. Д	Yes	X No	_
			insurance company fail to provide any inform		iete Scheaule	: A ?	169	NO NO	_
12	If t	ne ar	nswer to line 11 is "Yes," specify the informat	on not provided.					

Filing Authorization for the Form 5500

Name of Plan Sponsor: Kirk Auto Company, Inc.
Name of Plan: Kirk Auto Company, Inc. Employee Benefits Plan
EIN: <u>65-0535840</u>
Plan Number (ex 501): <u>501</u>
Plan Year Ending (mm/dd/yyyy): 12/31/2018
Part I: Authorization for Practitioner to Electronically Sign and File
I hereby authorize Consolidated Admin Services to electronically sign and file the above named return/report through EFAST2.
I understand that in granting this authority that:
 I/we must manually sign and date page 1 of the Form 5500, as Plan Administrator, and provide a scanned copy of page 1 and page 2 of the Form 5500 to Consolidated Admin Services before the electronic filing can be initiated. Consolidated Admin Services is required to retain a copy of this written authorization in its records; Consolidated Admin Services is required to notify the individual signing below as plan administrator/employer about any inquiries and information it receives from EFAST2, DOL, IRS or PBGC regarding this annual return/report; and A copy of my signature, as it appears on page 1 of the Form 5500 will be included in the return/report posted by the Department of Labor on the Internet for public disclosure Consolidated Admin Services shall not be deemed an administrator or other fiduciary with respect to any Plan solely on account of the services performed under this authorization.
This authorization is applicable only to the filing for the above-named Plan.
Plan Administrator: Deborah J. Adams Print Name
Plan Administrator: Debout Debout Date: 7-31-19

Part II: Use of Authorization Granted

Consolidated Admin Services will use the authority granted only for the express purposes described above; that the firm will not disclose confidential information to any parties other than the DOL, as required for EFAST2 filing; and that our firm will take reasonable steps to assure that confidential information provided by the Plan Administrator of Plan Sponsor is protected from unauthorized disclosure.