### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Annual Return/Report of Employee Benefit Plan

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

▶ Complete all entries in accordance with the instructions to the Form 5500. OMB Nos. 1210-0110 1210-0089

2018

This Form is Open to Public Inspection

Part I Annual Report Id	dentification Information	•				
For calendar plan year 2018 or fisc	cal plan year beginning 02/01/2018	and ending 01/31/2019				
A This return/report is for:		oust attach a list of th the form instruction	ns.)			
	X a single-employer plan	a DFE (specify)				
<b>B</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			•		
<b>D</b> Check box if filing under:	X Form 5558	automatic extension	the	e DFVC program		
	special extension (enter description					
Part II Basic Plan Inform	mation—enter all requested information	on				
1a Name of plan COMMERCE TECHNOLOGIES,	LLC MEDICAL WELFARE BENEFIT PL	AN	1b	Three-digit plan number (PN) ▶	502	
			1c	Effective date of pla 02/01/2015	an	
City or town, state or province	, apt., suite no. and street, or P.O. Box), country, and ZIP or foreign postal code	e (if foreign, see instructions)	2b	Employer Identifica Number (EIN) 14-1798555	tion	
COMMERCE TECHNOLOGIES, LLC  2c Plan Sponsor's telephone number 518-810-0700						
201 FULLER RD 6TH FL ALBANY, NY 12203-3621  201 FULLER RD 6TH FL ALBANY, NY 12203-3621			2d	Business code (see instructions) 541511	)	

### 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	10/07/2019 Date	MICHAEL TRIMARCHI  Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.  Signature of employer/plan sponsor	10/07/2019 Date	MICHAEL TRIMARCHI  Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2018) v. 171027

Page 2 Form 5500 (2018) **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN **3c** Administrator's telephone number If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: 4d PN Sponsor's name Plan Name Total number of participants at the beginning of the plan year 275 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). 275 a(1) Total number of active participants at the beginning of the plan year ...... 6a(1) 307 a(2) Total number of active participants at the end of the plan year ...... 6a(2)Retired or separated participants receiving benefits. 6b Other retired or separated participants entitled to future benefits...... 6c 307 6d Subtotal. Add lines 6a(2), 6b, and 6c. Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e 307 Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item) ..... Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested ...... 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)...... 7 If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: **b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4E 4D 4B 4F 4H 4Q

9h

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

(1)

(2)

(3)

(4)

(1)

(2)

(3)

(4)

(5)

(6)

**b** General Schedules

X

Plan benefit arrangement (check all that apply)

Code section 412(e)(3) insurance contracts

General assets of the sponsor

H (Financial Information)

3 A (Insurance Information)

I (Financial Information – Small Plan)

C (Service Provider Information)D (DFE/Participating Plan Information)

**G** (Financial Transaction Schedules)

Insurance

Trust

Plan funding arrangement (check all that apply)

Code section 412(e)(3) insurance contracts

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

General assets of the sponsor

R (Retirement Plan Information)

Insurance

Trust

actuary

(1)

(2)

(3)

(4)

(1)

(2)

(3)

a Pension Schedules

Form 5500 (2018)

Page 3

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

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

# **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

2018

pursuant to ERISA section 103(a)(2).						m is Open to Public Inspection	
For calendar plan year 20	18 or fiscal pla	an year beginning 02/01/2018		and en	ding 01/31	1/2019	
A Name of plan COMMERCE TECHNOLO	OGIES, LLC M	MEDICAL WELFARE BENEFIT I	PLAN		e-digit number (PN	ı) <b>&gt;</b>	502
C Plan sponsor's name a	OGIES, LLC			14-	1798555	ation Number	
		rning Insurance Contract  A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		DMPANY					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or c	ontract year
(b) LIN	code	identification number	policy or contract		(f)	From	<b>(g)</b> To
13-5581829	65978	TM05942716	764		02/01/2018	3	01/31/2019
2 Insurance fee and com- descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, b	orokers, and c	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
10719 7582					7582		
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to whor	n commiss	ions or fees	were paid	
BROWN & BROWN OF NE	EW YORK, IN	C. 6 TO' ALBA	WER PLACE NY, NY 12203				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	10719		SERVICE FEE, SUPPLEI MONETARY COMPENSA		OMPENSAT	TON, NON-	3
	(a) Name	and address of the agent, broke	er, or other person to whor	n commiss	ions or fees	were paid	
(b) Amount of sales ar	nd hase	F <sub>0</sub>	ees and other commission	ns paid			
		(c) Amount		(d) Purpose	е		(e) Organization code
	commissions paid (c) Amount (d) Purpose						

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
<b>(a)</b> 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
<b>(a)</b> Na	me and address of the agent, broker	r, 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>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
( <b>a)</b> 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>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(a) supers	code
<b>(a)</b> 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.			<b>-</b>				
		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 ▶							
		<del>-</del>							
	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 <b>7b</b> and <b>7c(6)</b> )			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	Bon	ofit o	nd contract type (check all applicable boxes)		amor may be	Troutou do a driit for p	<u> </u>	e reperti
•	г	_		<b>b</b> X Dental	۔ ۔	Vision		<b>d</b> ☐ Life insurance
	a [		ealth (other than dental or vision)	_	<u> </u>	1		- <del>-</del>
	е	Te	emporary disability (accident and sickness)	f Long-term disabilit	· - <u>-</u>	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)					
9	Ехр€	erien	ce-rated contracts:					
	a	Prem	iums: (1) Amount received		9a(1)			
		(2) lı	ncrease (decrease) in amount due but unpaid	t	9a(2)			
		(3) lı	ncrease (decrease) in unearned premium res	erve	9a(3)			
		. ,	Earned ( <b>(1) + (2) - (3)</b> )				. 9a(4)	
	b		efit charges (1) Claims paid		` '			
		` '	ncrease (decrease) in claim reserves		. , ,		01 (0)	
			ncurred claims (add (1) and (2))				9b(3)	
	_	` '	Claims charged				. 9b(4)	
	С		nainder of premium: (1) Retention charges (c	·	00/1)/(1)			
			(A) Commissions(B) Administrative service or other fees		9c(1)(A) 9c(1)(B)			
			(C) Other specific acquisition costs		0 (4)(0)			
			(D) Other expenses		0 (4)(D)			
			(E) Taxes					
			(F) Charges for risks or other contingencies		9c(1)(F)			
			(G) Other retention charges		9c(1)(G)			
			(H) Total retention				. 9c(1)(H)	
		(2) I	Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d		us of policyholder reserves at end of year: (1	_	_		• • •	
			Claim reserves				. 9d(2)	
		(3)	Other reserves				. 9d(3)	
	е	Divi	dends or retroactive rate refunds due. (Do n	ot include amount entered	d in line <b>9c(2)</b> .	.)	. 9e	
10	No	nexp	erience-rated contracts:					
	а	Tota	al premiums or subscription charges paid to o	arrier			. 10a	242453
	b		e carrier, service, or other organization incur	, ,		•		
	C n n		ntion of the contract or policy, other than rep	orted in Part I, line 2 abov	e, report amo	ount	10b	
	Spe	City i	nature of costs.					
P	art	IV	Provision of Information					
			insurance company fail to provide any inform	nation necessary to compl	ata Schadula	Δ2 Π	Yes	X No
			Insurance company fall to provide any informations are to line 11 is "Yes," specify the informations.		ere ochedule	Λ!	100	
14	II (	ne ar	iswel to lille 11 is Tes, specily the informat	on not provided.				

# **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2018

		pursuant to E	RISA section 103(a)(2).				Inspection
For calendar plan year 20	18 or fiscal plan	year beginning 02/01/2018		and en	ding 01/3	1/2019	
A Name of plan COMMERCE TECHNOLO	OGIES, LLC ME	EDICAL WELFARE BENEFIT PLA	AN		e-digit number (PI	N) •	502
C Plan sponsor's name a COMMERCE TECHNOLO		e 2a of Form 5500			yer Identific 1798555	ation Number (	EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		INC.					
/L\ FIN	(c) NAIC	(d) Contract or	(e) Approximate nur			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To
23-7391136	55093	721171	534		02/01/2018	8	01/31/2019
2 Insurance fee and com- descending order of the		tion. Enter the total fees and tota	l commissions paid. Lis	t in line 3	the agents,	brokers, and of	her persons in
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid						
		144485					
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all p	ersons).			
		nd address of the agent, broker, o	· · · · · · · · · · · · · · · · · · ·	commiss	ions or fees	were paid	
BROWN & BROWN OF NE	EW YORK, INC	21ST FL	ROADWAY LOOR DRK, NY 10036				
(b) Amount of sales ar	nd base	Fees	s and other commissions	s paid			
commissions pa	id	(c) Amount	(0	(d) Purpose			(e) Organization code
	7800						3
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commissi	ions or fees	were paid	
BROWN & BROWN OF NE		. 500 PLU SUITE 2	JM ST.			·	
(b) Amount of sales ar	nd hase	Fees	s and other commissions	s paid			
commissions pa		(c) Amount		d) Purpose	9		(e) Organization code
	136685						3
E B	n Act Notice o	and the Instructions for Form El	-00			Cabaa	

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
<b>(a)</b> 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
<b>(a)</b> Na	me and address of the agent, broker	r, 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>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
( <b>a)</b> 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>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
<b>(a)</b> 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.			<b>-</b>				
		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 ▶							
		<del>-</del>							
	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 <b>7b</b> and <b>7c(6)</b> )			7d				
		Deductions:	7-(4)						
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)						
		(2) Administration charge made by carrier	7e(2)						
		(3) Transferred to separate account	7e(3) 7e(4)						
		(4) Other (specify below)	. /e(4)						
		•							
		(5) Total deductions			7e(5)				
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f				

P	art I	If more than one the information m	efit Contract Inform contract covers the same ay be combined for repor ntire group of such individ	group of employed	ch contracts are exp	erience-rated as a un	it. Where co	ontracts cover individu	
8	Bene	it and contract type (c	neck all applicable boxes)						
	a	Health (other than de	ntal or vision)	<b>b</b> Dental	c×	Vision		<b>d</b> Life insurance	
	еĒ	Temporary disability	(accident and sickness)	f Long-term	disability g	Supplemental unem	ployment	h Prescription di	rug
	ιĖ	Stop loss (large dedu		j HMO contr	·	PPO contract	' '	I Indemnity cont	
	<u> </u>		otibio)	, I mile com	uot K	1 1 0 contract			1400
	m _	Other (specify)							
a	Evne	ence-rated contracts:							
5	•		eceived		9a(1)			_	
		` '	in amount due but unpai		· · · · · ·				
			in unearned premium res						
		,	3))				9a(4)		
		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ims paid						
		2) Increase (decrease)	in claim reserves		9b(2)				
		3) Incurred claims (add	d (1) and (2))				. 9b(3)		
	(	4) Claims charged					. 9b(4)		
	С	Remainder of premium	: (1) Retention charges (d	on an accrual basis					
		(A) Commissions							
		` '	service or other fees		0. (4)(0)			_	
		. ,	acquisition costs		0. (4)(D)				
		. ,	3		0-(4)(5)			_	
			······································						
		(C) Other retention	s or other contingencies.		9c(1)(G)				
							9c(1)(H)	)	
		` '	ctive rate refunds. (These		_			/	
			reserves at end of year: (1	L-1					
	u								
		,							
		,	e rate refunds due. (Do n						
10		experience-rated cont				,			
	а	Total premiums or sub	scription charges paid to	carrier			10a		2911801
	_		r other organization incur et or policy, other than rep				10b		
Pi	_	etention of the contractify nature of costs.	et or policy, other than rep				., 10b		
							Vaa	V Na	
			y fail to provide any inforn			e A?	Yes	X No	
12	If th	e answer to line 11 is "	Yes," specify the informat	ion not provided.	<b>•</b>				

# **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

2018

						m is Open to Public Inspection				
For calendar plan year 20										
A Name of plan COMMERCE TECHNOL	OGIES, LLC N	MEDICAL WELFARE BENEFIT F	OL ANI	hree-digit lan number (PN)	•	502				
C Plan sponsor's name a		ne 2a of Form 5500		nployer Identification 14-1798555	n Number (	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		NCE COMPANY		. 1	Deli					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year		•	ontract year (g) To				
20-5876774	13573	AL00005441	307	02/01/2018		01/31/2019				
2 Insurance fee and com descending order of the			otal commissions paid. List in line	e 3 the agents, brok	kers, and of	ther persons in				
(a) Total amount of commissions paid (b) Total amount of fees paid										
12487 2819						2819				
3 Persons receiving com	nmissions and	fees. (Complete as many entrie	es as needed to report all persons	s).						
			r, or other person to whom comm	nissions or fees wer	re paid					
BROWN & BROWN OF N	EW YORK, IN	SUIT	PLUM ST. E 200 ACUSE, NY 13204							
(b) Amount of sales a	nd base	F	ees and other commissions paid							
commissions pa		(c) Amount	<b>(d)</b> Purp	oose		(e) Organization code				
	5507					3				
	(a) Name	and address of the agent, broke	r, or other person to whom comm	nissions or fees wer	re paid					
BROWN & BROWN INS A	AGY OF VA IN		OX 3070 MOND, VA 23228							
(b) Amount of sales a	nd base	F	ees and other commissions paid							
commissions pa	aid	(c) Amount	<b>(d)</b> Purp			(e) Organization code				
	2653 BONUS, OVERRIDE, NON MONETARY COMPENSATION				SATION	3				

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

(b) Amount of sales and base

commissions paid

(c) Amount

Page	2 –	1

(d) Purpose

Organization

code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid BROWN & BROWN OF NEW YORK, INC. **6 TOWER PLACE** ALBANY, NY 12203 Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code BONUS, OVERRIDE, NON MONETARY COMPENSATION 6980 166 3 (a) Name 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 Organization (c) Amount (d) Purpose commissions paid code (a) Name 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 Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) Organization (b) Amount of sales and base (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e)

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 a	as a unit for purposes of
		this report.				
		ent value of plan's interest under this contract in the general account at year			4	
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount.			<b>-</b>	
		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 ▶				
		<del>-</del>				
	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 <b>7b</b> and <b>7c(6)</b> )			7d	
		Deductions:	7-(4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3) 7e(4)			
		(4) Other (specify below)	. /e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

P	art I	II	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individ	group (	of em	es if such	contracts a	е ехр	erience-rated as a un	it. Where c	ontracts c	over individual
8	Bene	efit a	nd contract type (check all applicable boxes)									
	а	Не	ealth (other than dental or vision)	b	Den	ital		С	Vision		d X Lif	fe insurance
	e X	Τe	emporary disability (accident and sickness)	f X	Lone	g-term dis	ability	g	Supplemental unen	nployment	<b>h</b> ☐ Pr	escription drug
	i F	-	op loss (large deductible)	브		o O contract	-		PPO contract	. ,	_ ;;;	demnity contract
	<u>_</u>	_		, <sub>□</sub>	1 11010	o ooninadi	•		1 1 0 contract			zonimity 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)		
		. ,	efit charges (1) Claims paid									
	(	(2) lı	ncrease (decrease) in claim reserves				9b(	2)				
		(3) lı	ncurred claims (add (1) and (2))							9b(3)		
	(	(4) (	Claims charged							9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	n an a	ccrua	al basis) -	-					
			(A) Commissions									
			(B) Administrative service or other fees				0.74					
			(C) Other specific acquisition costs				0.74					
			(D) Other expenses				0-14	-				
			(E) Taxes								_	
			(F) Charges for risks or other contingencies			•••••	9c(1)	(G)				
			(G) Other retention charges(H) Total retention							9c(1)(H	1	
			Dividends or retroactive rate refunds. (These			_		_			<b>,</b>	
			tus of policyholder reserves at end of year: (1									
	u		Claim reserves									
		` '	Other reserves							:-:		
		` '	dends or retroactive rate refunds due. (Do n									
10			perience-rated contracts:					,	7			
			al premiums or subscription charges paid to d	arrier.						10a		119049
	b	If th	e carrier, service, or other organization incur- ntion of the contract or policy, other than rep- nature of costs.	ed any	y spe	cific costs	in connecti	on wit	th the acquisition or			
В	Spec	cify r	nature of costs.	ortea ir	n Par	t I, line 2 t	above, repo	rt amo	ount	100		
	art I		Provision of Information							1		
11	Did	the	insurance company fail to provide any inform	ation r	neces	ssary to co	omplete Sch	nedule	A?	Yes	× No	
12	lf th	ne ar	nswer to line 11 is "Yes," specify the informat	on not	t prov	vided.						