Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2018

Administration		the instru	ctions to the Form 55	000.			
Pensio	n Benefit Guaranty Corporation				This F	Form is Open to Pu Inspection	aplic
Part I	Annual Report Id	entification Information					
For caler	ndar plan year 2018 or fisc	al plan year beginning 04/01/2018		and ending 04/01/20)19		
A This	return/report is for:	a multiemployer plan		oloyer plan (Filers checking the moloyer information in accor			ns.)
		x a single-employer plan	a DFE (specify	<u> </u>			
B This i	return/report is:	X the first return/report	the final return	•			
		an amended return/report	a short plan ye	ear return/report (less than 12	2 months)		
C If the	plan is a collectively-barga	nined plan, check here				• 🗌	
D Chec	k box if filing under:	Form 5558	automatic exter	nsion	the	DFVC program	
		special extension (enter description	on)				
Part II	Basic Plan Inform	nation—enter all requested informa	tion				
	ne of plan RCRAFT MAINTENANCE	(MIAMI) LLC			1b	Three-digit plan number (PN) ▶	501
					1c	Effective date of pla 04/01/2018	an
Mail City	sponsor's name (employe ing address (include room, or town, state or province,	uctions)	2b Employer Identification Number (EIN) 52-2177585				
F&E AIR	CRAFT MAINTENANCE (I	MIAMI), LLC			2c	Plan Sponsor's tele number 305-871-3758	
657 SOUTH DRIVE SUITE 306 MIAMI SPRINGS, FL 33166		657 SOUTH DRIVE SUITE 306 MIAMI SPRINGS, FL 33166			2d Business code (see instructions)		Э
Caution	: A penalty for the late or	incomplete filing of this return/rep	ort will be assessed	unless reasonable cause is	s establis	hed.	
		er penalties set forth in the instructions all as the electronic version of this retu					
SIGN HERE	Filed with authorized/valid	electronic signature.	10/30/2019	GUY TICKNER			
	Signature of plan admir	nistrator	Date	Enter name of individual s	igning as ¡	plan administrator	
SIGN							

Date

Date

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

Signature of employer/plan sponsor

Signature of DFE

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

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 562 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). 562 a(1) Total number of active participants at the beginning of the plan year 6a(1) 562 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 562 6d Subtotal. Add lines 6a(2), 6b, and 6c. Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e 562 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: 4D 4E 4B 4Q 4Q 4Q 4Q Plan funding arrangement (check all that apply) 9h Plan benefit arrangement (check all that apply) (1) Insurance (1) 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

Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules **b** General Schedules R (Retirement Plan Information) (1) (1) H (Financial Information) (2) I (Financial Information – Small Plan) MB (Multiemployer Defined Benefit Plan and Certain Money (2) X (3) 8 A (Insurance Information) Purchase Plan Actuarial Information) - signed by the plan actuary (4) **C** (Service Provider Information) **D** (DFE/Participating Plan Information) (5) (3)SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary **G** (Financial Transaction Schedules) (6)

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

2018

		pursuant to Ef	RISA section 103(a)(2).			111101011	Inspection
For calendar plan year 20	18 or fiscal plar	year beginning 04/01/2018		and en	ding 04/0	1/2019	
A Name of plan F&E AIRCRAFT MAINTE	NANCE (MIAM	I) LLC		B Three plan	e-digit number (PN	N) •	501
C Plan sponsor's name a F&E AIRCRAFT MAINTE					yer Identifica 2177585	ation Number (EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca UNITED HEALTHCARE IN		DMPANY					
ALL FINI	(c) NAIC	(d) Contract or	(e) Approximate nun			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at o		(f)	From	(g) To
36-2739571	79413	417003412469	329		04/01/2018	8	04/01/2019
descending order of the	amount paid.	ation. Enter the total fees and total	I commissions paid. List	t in line 3	the agents,	brokers, and of	her persons in
(a) Total a	amount of comr	nissions paid 157836		(b) To	tal amount	of fees paid	220240
		137636					239348
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		commissi	ions or fees	were paid	
HUDSON SHORE GROUP)	SUITE 3	ST FRONT STREET 110 NK, NJ 07701				
(b) Amount of sales ar	nd hase	Fees	and other commissions	s paid			
commissions pai		(c) Amount	(d	d) Purpose	Э		(e) Organization code
							3
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commissi	ions or fees	were paid	
		•					
(b) Amount of sales ar	nd base	Fees	and other commissions	s paid			
commissions pai		(c) Amount	(d	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				
		From and other constitutions and	(-)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
	T					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
, ,	<u> </u>					
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
•						
(a) Na	The standard of the stand business					
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization			
commissions paid	(0,1	(a) supers	code			
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
	T		1			
(h) Amount of sales and hase		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code			
			Organization			

F	Part	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	

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	ting purposes if such conti	racts are expe	erience-rated as a un	it. Where co	ontracts cover individual
8	Ben	efit aı	nd contract type (check all applicable boxes)					
	а	X He	alth (other than dental or vision)	b Dental	С	Vision		d Life insurance
	еĪ		mporary disability (accident and sickness)	f Long-term disabilit	_	Supplemental unem	plovment	h Prescription drug
	. F	_	op loss (large deductible)	j HMO contract	_	PPO contract		I Indemnity contract
	' <u>'</u>			I I I I I I I I I I I I I I I I I I I	κ	FFO Contract		
	m	Ot	her (specify)					
α .	Evn	oriona	e-rated contracts:					
			iums: (1) Amount received		00/1)			
	а		ncrease (decrease) in amount due but unpaid		9a(1) 9a(2)			
			ncrease (decrease) in amount due but unpaid					
			arned ((1) + (2) - (3))				. 9a(4)	
	b		efit charges (1) Claims paid					
			ncrease (decrease) in claim reserves					
		(3) Ir	ncurred claims (add (1) and (2))				. 9b(3)	
		(4) C	laims charged				. 9b(4)	
	С	Rem	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				9c(1)(H)	1
			H) Total retention Dividends or retroactive rate refunds. (These					<i>)</i>
	a			_	_		` ` `	
	d		us of policyholder reserves at end of year: (1 Claim reserves				. 9d(1) . 9d(2)	
		` '	Other reserves				9d(3)	
	е	` '	dends or retroactive rate refunds due. (Do n					
10	_		erience-rated contracts:			,		
	а		l premiums or subscription charges paid to o	arrier			. 10a	691074
	b	If the	e carrier, service, or other organization incur	red any specific costs in c	onnection witl	h the acquisition or		
	Sno		ntion of the contract or policy, other than reparture of costs.	orted in Part I, line 2 abov	e, report amo	ount	10b	
	Ope	City II	ature or costs.					
Pa	art	IV	Provision of Information					
11	Dio	d the	insurance company fail to provide any inform	nation necessary to compl	ete Schedule	А?	Yes	X No
			swer to line 11 is "Yes," specify the informat					
			entrological services and the services and the services are ser					

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

For calendar plan year 2018 or fiscal plan year beginning 04/01/2018 and ending 04/01/2019 A Name of plan (a) Name of insurance carrier UNITED OF OMAHA LIFE INSURANCE COMPANY (b) EIN (c) NAIC code (300 AZTD (400 AZT)) 2 Insurance fee and commission from the total fees and total commissions paid (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount of sales and base commissions paid (d) Purpose (e) Organization code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			pursuant to E	RISA section 103(a)(2)).		111101011	Inspection
C Plan sponsor's name as shown on line 2a of Form 5500 F&E AIRCRAFT MAINTENANCE (MIAMI), LLC 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 carrier UNITED OF OMAHA LIFE INSURANCE COMPANY (b) EIN (c) NAIC code identification number policy or contract year persons covered at end of policy or contract year polic	For calendar plan year 201	18 or fiscal plar	n year beginning 04/01/2018		and en	nding 04/0	1/2019	
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 carrier UNITED OF OMAHA LIFE INSURANCE COMPANY (b) EIN (c) NAIC code identification number of identification number of persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons overed at end of policy or contract year persons		NANCE (MIAM	II) LLC			J	N) •	501
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 carrier UNITED OF OMAHA LIFE INSURANCE COMPANY (b) EIN (c) NAIC code identification number of identification number of persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons overed at end of policy or contract year persons								
on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier UNITED OF OMAHA LIFE INSURANCE COMPANY (b) EIN (c) NAIC code identification number policy or contract year poli	•						ation Number (EIN)
(a) Name of insurance carrier UNITED OF OMAHA LIFE INSURANCE COMPANY (b) EIN (c) NAIC code identification number persons covered at end of policy or contract year persons covered at end of policy or contract year (f) From (g) To 47-0322111 69868 G000AZTD 562 04/01/2019 04/01/2019 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 9688 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid HUDSON SHORE GROUP (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 3								
(c) NAIC code (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year (f) From (g) To (g) To (h) From	1 Coverage Information:							
(b) EIN (c) NAIC code identification number persons covered at end of policy or contract year (f) From (g) To 47-0322111 69868 G000AZTD 562 04/01/2019 04/01/2019 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 9688 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid HUDSON SHORE GROUP 141 WEST FRONT STREET SUITE 310 RED BANK, NJ 07701 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 3			COMPANY					
47-0322111 69868 G000AZTD 562 04/01/2019 04/01/2019 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 9688 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid HUDSON SHORE GROUP 141 WEST FRONT STREET SUITE 310 RED BANK, NJ 07701 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 3	/L\ FINI	(c) NAIC	(d) Contract or				Policy or co	ontract year
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 9688 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid HUDSON SHORE GROUP 141 WEST FRONT STREET SUITE 310 RED BANK, NJ 07701 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	(b) EIN					(f)	From	(g) To
descending order of the amount paid. (a) Total amount of commissions paid 9688 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid HUDSON SHORE GROUP 141 WEST FRONT STREET SUITE 310 RED BANK, NJ 07701 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	47-0322111	69868	G000AZTD	562	2	04/01/2019	9	04/01/2019
9688 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid 141 WEST FRONT STREET SUITE 310 RED BANK, NJ 07701 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 3			ation. Enter the total fees and tota	al commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid HUDSON SHORE GROUP 141 WEST FRONT STREET SUITE 310 RED BANK, NJ 07701 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	(a) Total a	amount of comm			(b) To	otal amount	of fees paid	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid HUDSON SHORE GROUP 141 WEST FRONT STREET SUITE 310 RED BANK, NJ 07701 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code								
HUDSON SHORE GROUP 141 WEST FRONT STREET SUITE 310 RED BANK, NJ 07701 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 3	3 Persons receiving com			•				
commissions paid (c) Amount (d) Purpose (e) Organization code 3	HUDSON SHORE GROUP		141 WE SUITE :	ST FRONT STREET 310	m commiss	ions or fees	were paid	
3	(b) Amount of sales an	nd base	Fee	s and other commission	ns paid			
	commissions pai	id	(c) Amount		(d) Purpos	е		(e) Organization code
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								3
		(a) Name a	and address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid	
(b) Amount of sales and base Fees and other commissions paid	(b) Amount of sales an	nd base	Fee	s and other commission	ns paid			
	` '		(c) Amount		(d) Purpos	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			

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	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 ting p	p of e	oses if	such co	ntracts a	re exp	erie	ence-rated as a un	it. Where c	contract	ts cover individual	
8	Bene	efit a	and contract type (check all applicable boxes)												
	а	Не	ealth (other than dental or vision)	b	De	ental			С	٧	/ision		d X	Life insurance	
	еĪ	Τe	emporary disability (accident and sickness)	f 🗍	= Lc	ong-ter	rm disab	oility	g	ī īs	Supplemental unem	ployment	h∏	Prescription drug	
	ιĖ	=	op loss (large deductible)	ιĖ		MO co		,			PPO contract	, ,	- =	Indemnity contract	
	_ _	_		, _	」	WIO 00	milaot		•`∟	」'	1 O dominadi		•П	macming contract	
	m [_ 0	ther (specify)												
a	Evne	rion	ce-rated contracts:												
5	•		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												
		(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 ba	asis)		1						
			(A) Commissions												
			(B) Administrative service or other fees					0.74							
			(C) Other specific acquisition costs					0.74							
			(D) Other expenses					0-/4							
			(E) Taxes												
			(F) Charges for risks or other contingencies.(G) Other retention charges					0-/4							
			(H) Total retention							<u> </u>		. 9c(1)(H	I)		
			Dividends or retroactive rate refunds. (These				_		_				'		
	d		tus of policyholder reserves at end of year: (1												
	u		Claim reserves									. 9d(1)			
		` '	Other reserves												
	е	` '	dends or retroactive rate refunds due. (Do n												
10			perience-rated contracts:							,		•			
	а	Tota	al premiums or subscription charges paid to o	carrier	r							. 10a		96	876
	_	rete	e carrier, service, or other organization incur- ention of the contract or policy, other than rep- nature of costs.									. 10b			
P	_	rete	ention of the contract or policy, other than rep									. 10b			
			insurance company fail to provide any inform	nation	nec	cessar	v to com	nlete Sc	hedule	- Δ΄	? П	Yes	X N	0	
								ipiete Sc	nedule	e A	·	169	^ IN		_
12	If th	ne ai	nswer to line 11 is "Yes," specify the informat	ion no	ot pro	ovided	d. ₽								

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)			111101011	Inspection
For calendar plan year 20	18 or fiscal plar	year beginning 04/01/2018		and en	ding 04/0	1/2019	
A Name of plan F&E AIRCRAFT MAINTE	NANCE (MIAM	I) LLC		B Three	e-digit number (PN	u) >	501
C Plan sponsor's name a F&E AIRCRAFT MAINTE					yer Identifica 2177585	ation Number (EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
47-0322111	7-0322111 69868 G000AZTD		126	6	04/01/2018	3	04/01/2019
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents, l	brokers, and o	ther persons in
(a) Total a	amount of comm			(b) To	otal amount o	of fees paid	
		9046					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
HUDSON SHORE GROUP)	SUITE 3	ST FRONT STREET 310 ANK, NJ 07701				
(b) Amount of sales ar	nd hase	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
							3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns 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			

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 Information if more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group ing p	of e	ses if such	n contra	cts are e	xpe	erience-rated as a uni	t. Where c	ontract	ts cover individual
8	Ben	efit a	nd contract type (check all applicable boxes)										
	а「	Не	ealth (other than dental or vision)	b	De	ental		С	П	Vision		d	Life insurance
	е	=	emporary disability (accident and sickness)	f	=	ng-term di	isahility		님	Supplemental unem	nlovment	h∏	
		_		:		-	-	_	므		pioyinoni	- =	
	! [_	op loss (large deductible)	J [HIV	//O contrac	CT	k	, Ц	PPO contract		' 📙	Indemnity contract
	m	Κ O	ther (specify) SHORT-TERM DISABILITY										
_													
9	•		ce-rated contracts:					0 (4)					
	a i		niums: (1) Amount received				<u> </u>	9a(1)					
			ncrease (decrease) in amount due but unpaid					9a(2)					
		` '	ncrease (decrease) in unearned premium res					9a(3)			00(4)		
	b	. ,	Earned ((1) + (2) - (3)) uefit charges (1) Claims paid						Τ		. 9a(4)		
	D		ncrease (decrease) in claim reserves						+				
			ncurred claims (add (1) and (2))								. 9b(3)		
			Claims charged								9b(3)		
	С	` '	nainder of premium: (1) Retention charges (c								. 35(4)		
			(A) Commissions					9c(1)(A)	1				
			(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))				
			(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	amo	ounts	were p	oaid in d	cash, or	С	credited.)	9c(2)		
	d	Stat	tus of policyholder reserves at end of year: (1) Am	ount	held to pro	ovide b	enefits af	ter	retirement	. 9d(1)		
		(2)	Claim reserves								. 9d(2)		
		(3)	Other reserves								. 9d(3)		
	е	Divi	dends or retroactive rate refunds due. (Do n	ot inc	lude	amount ei	ntered i	n line 9c	(2).)	. 9e		
10	No	nexp	perience-rated contracts:										
	а	Tota	al premiums or subscription charges paid to o	arrie	r						. 10a		90457
	b Spe	rete	e carrier, service, or other organization incurrention of the contract or policy, other than rep- nature of costs.								. 10b		
P	Spe	cify r				, =		, 10port a.					
												<u> </u>	
11	Dic	the !	insurance company fail to provide any inform	ation	nec	essary to	complet	te Schedu	ule	A?	Yes	X N	3
12	lf tl	ne ar	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

2018

		pursuant to E	RISA section 103(a)(2)			111101011	Inspection
For calendar plan year 20	18 or fiscal plar	year beginning 04/01/2018		and en	ding 03/3	1/2019	
A Name of plan F&E AIRCRAFT MAINTE	NANCE (MIAM	I) LLC		B Three	e-digit number (PN	u) >	501
C Plan sponsor's name a F&E AIRCRAFT MAINTE					oyer Identifica 2177585	ation Number (EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		COMPANY					
<i>a</i> > =	(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
47-0322111	69868	G000AZTD	158	3	04/01/2018	3	04/01/2019
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	ıl commissions paid. Li	ist in line 3	the agents, I	brokers, and o	ther persons in
(a) Total a	amount of comm			(b) To	otal amount o	of fees paid	
		2388					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid	
HUDSON SHORE GROUP)	SUITE 3	ST FRONT STREET 310 NK, NJ 07701				
(b) Amount of sales ar	nd hase	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
							3
	(a) Name a	nd address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai		(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	
		For any distribution and section and the section of	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part	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	II	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individuals.	group	p of e	ses if such	n contr	acts are	expe	erience-rated as a un	it. Where c	contract	s cover individual
8	Ben	efit a	nd contract type (check all applicable boxes)								<u></u>		
Ŭ	a [_	ealth (other than dental or vision)	b	ا ا	ental			с□	Vision		d∏	Life insurance
	_ L	_			_							브	
	e [_	emporary disability (accident and sickness)	' <u> </u>	_	ong-term di		-	g ∐	Supplemental unem	ipioyment	- =	Prescription drug
	i	St	op loss (large deductible)	j L	HN	MO contrac	ct		k _	PPO contract		ıШ	Indemnity contract
	m	(O	ther (specify) FCRITICAL ILLNESS VOLUM	ITAR	Υ								
_													
9	•		ce-rated contracts:				г						
	a I		niums: (1) Amount received				-	9a(1)				-	
			ncrease (decrease) in amount due but unpai				T		_				
		` '	ncrease (decrease) in unearned premium res				L	•			0-(4)		
	h	. ,	Earned ((1) + (2) - (3))				Г				. 9a(4)		
	b		efit charges (1) Claims paid				-						
			ncrease (decrease) in claim reservesncurred claims (add (1) and (2))								. 9b(3)		
			Claims charged								9b(3)		
	С	` '	nainder of premium: (1) Retention charges (c								. 30(+)		
	·		(A) Commissions				Г	9c(1)(Δ)				
			(B) Administrative service or other fees										
			(C) Other specific acquisition costs				-	9c(1)(
			(D) Other expenses				F	9c(1)(l	D)				
			(E) Taxes					9c(1)(l	Ξ)				
			(F) Charges for risks or other contingencies.				[9c(1)(l	-)				
			(G) Other retention charges					9c(1)(3)				
			(H) Total retention								. 9c(1)(H	l)	
		(2) I	Dividends or retroactive rate refunds. (These	amo	ounts	were p	oaid in	cash, or		credited.)	9c(2)		
	d	Stat	tus of policyholder reserves at end of year: (1) Am	ount	held to pro	ovide l	penefits a	after	retirement	. 9d(1)		
		(2)	Claim reserves								. 9d(2)		
		` '	Other reserves										
			dends or retroactive rate refunds due. (Do n	ot inc	lude	amount e	ntered	in line 9	c(2).	.)	. 9e		
10	No		perience-rated contracts:										
	а	Tota	al premiums or subscription charges paid to d	arrie	r				•••••		. 10a		23876
	b Spe	rete	e carrier, service, or other organization incur ntion of the contract or policy, other than rep nature of costs.								. 10b		
Р	art l	V	Provision of Information										
11	Dic	l the	insurance company fail to provide any inform	nation	ı nec	essary to	comple	ete Sche	dule	A?	Yes	X No	o
12	lf tl	ne ar	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

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OMB No. 1210-0110

2018

		pursuant to El	RISA section 103(a)(2).			110 1 011	Inspection
For calendar plan year 20	18 or fiscal plar	year beginning 04/01/2018		and en	ding 04/0	1/2019	
A Name of plan F&E AIRCRAFT MAINTE	NANCE (MIAM	I) LLC		B Three	e-digit number (PN	N) •	501
C Plan sponsor's name a F&E AIRCRAFT MAINTE					yer Identifica 2177585	ation Number (EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nui			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
47-0322111	69868	G000AZTD	155		04/01/2018	3	04/01/2019
2 Insurance fee and compute descending order of the		ation. Enter the total fees and tota	I commissions paid. Lis	st in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comr	nissions paid 5142		(b) To	otal amount	of fees paid	
		3142					
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all p	ersons).			
LILIDOON OLIODE ODOLIO		nd address of the agent, broker, o		commiss	ions or fees	were paid	
HUDSON SHORE GROUP		SUITE 3	ST FRONT STREET 110 NK, NJ 07701				
(b) Amount of sales ar	nd base	Fees	and other commission	s paid			
commissions pai		(c) Amount	(1	d) Purpose	е		(e) Organization code
							3
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commissi	ions or fees	were paid	
		_				·	
(b) Amount of sales ar	nd base	Fees	and other commission	s paid			
commissions pai		(c) Amount	(1	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

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	

Ρ	art III	Welfare Benefit Contract Informa											
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ting pu	urpos	es if such o	contra	cts are	expe	rience-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	Der	ntal		(С	Vision		d	Life insurance	
	e ∏ -	Temporary disability (accident and sickness)	f 🗏	Lor	g-term dis	abilitv		9 🗖	Supplemental unemp	olovment	h∏	Prescription drug	
		Stop loss (large deductible)	ı E		O contract	-	_		PPO contract	,	ıH	Indemnity contract	
			_ ر] ' '''	O contract			`	110 contract		.⊓	macming contract	
	m X	Other (specify) ACCIDENT											
9		non rated contractor											
J	•	nce-rated contracts: miums: (1) Amount received				Г	02/1)						
		Increase (decrease) in amount due but unpaid				<u> </u>	9a(1) 9a(2)						
	` '	Increase (decrease) in unearned premium res				<u> </u>	9a(3)						
		Earned ((1) + (2) - (3))				_				9a(4)			
	_ ` '	enefit charges (1) Claims paid					9b(1)						
		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 (c	n an a	accru	al basis)	_							
		(A) Commissions					9c(1)(A						
		(B) Administrative service or other fees					9c(1)(E						
		(C) Other specific acquisition costs				_	9c(1)(C	_					
		(D) Other expenses					9c(1)(D						
		(E) Charges for risks or other contingencies				<u> </u>	9c(1)(E 9c(1)(F	_					
		(F) Charges for risks or other contingencies(G) Other retention charges					9c(1)(G						
		(H) Total retention				L				9c(1)(H)		
	(2)) Dividends or retroactive rate refunds. (These			_			_			_		
		ratus of policyholder reserves at end of year: (1			ш		,			9d(1)			
		Claim reserves	•							9d(2)			
	` ') Other reserves								9d(3)			
		vidends or retroactive rate refunds due. (Do n								9e			
10		xperience-rated contracts:							,	•			
	a To	otal premiums or subscription charges paid to c	carrier	·						10a		51	420
	b If	the carrier, service, or other organization incur	red an	ny spe	ecific costs	in co	nnection	with	n the acquisition or				
		tention of the contract or policy, other than rep	orted i	in Pa	rt I, line 2 a	above	, report a	amo	unt	10b			
	Specify	nature of costs.											
													_
Р	art IV	Provision of Information											
11	Did th	e insurance company fail to provide any inform	nation	nece	ssarv to co	mple	te Scher	dule	А? П	Yes	X N	0	
		answer to line 11 is "Yes," specify the informat											
		and the first of the opening the information		pi 0									

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 El	RISA section 103(a)(2).			110 1 011	Inspection
For calendar plan year 20	18 or fiscal plar	year beginning 04/01/2018	T	and en	ding 04/0	1/2019	
A Name of plan F&E AIRCRAFT MAINTE	A Name of plan F&E AIRCRAFT MAINTENANCE (MIAMI) LLC				e-digit number (PN	N) •	501
C Plan sponsor's name a F&E AIRCRAFT MAINTE					yer Identifica 2177585	ation Number (EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
47-0322111	69868	G000AZTD	119		04/01/2018	3	04/01/2019
2 Insurance fee and compute descending order of the		ation. Enter the total fees and tota	l commissions paid. Lis	st in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comm			(b) To	otal amount	of fees paid	
		5491					
3 Persons receiving com		ees. (Complete as many entries a					
LILIDOON OLIODE ODOLIO		nd address of the agent, broker, o		n commiss	ions or fees	were paid	
HUDSON SHORE GROUP		SUITE 3	ST FRONT STREET 310 .NK, NJ 07701				
(b) Amount of sales ar	nd base	Fees	s and other commission	s paid			
commissions pai		(c) Amount		d) Purpose	Э		(e) Organization code
							3
	(a) Name a	nd address of the agent, broker, o	or other person to whom	n commiss	ions or fees	were paid	
		_				·	
(b) Amount of sales ar	nd base	Fees	s and other commission	s 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		ooguioition or	6d	_				
		retention of the contract or policy, enter amount.			<u> </u>					
		Specify nature of costs								
	е	Type of contract: (1) individual policies (2) group deferred	d annuity							
		(3) other (specify)								
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	ating plan, checl	k here						
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separ	ate accounts)						
	а	Type of contract: (1) deposit administration (2) immedia	ite participation g	juarantee						
		(3) guaranteed investment (4) other								
		_								
	b	Balance at the end of the previous year			7b	_				
	С	Additions: (1) Contributions deposited during the year	. 7c(1)							
		(2) Dividends and credits	7c(2)							
		(3) Interest credited during the year	7c(3)							
		(4) Transferred from separate account	. 7c(4)							
		(5) Other (specify below)	. 7c(5)							
		•								
		(6)Total additions			′c(6)					
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d					
		Deductions:	- (4)							
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)							
		(2) Administration charge made by carrier	7e(2)							
		(3) Transferred to separate account	7e(3) 7e(4)							
		(4) Other (specify below)	. /e(4)							
		•								
					(5)					
		(5) Total deductions			'e(5)					
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	_				

Ρ	art III							
		If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual.	ing purposes if such con	tracts are expe	erience-rated as a unit.	Where conti	tracts cover individual),
8	Benef	it and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	с□	Vision	d	Life insurance	
	е 🗍	Temporary disability (accident and sickness)	f X Long-term disabil	ity g	Supplemental unemplo	yment h	Prescription drug	
	iΪ	Stop loss (large deductible)	j HMO contract		PPO contract	ĺ	Indemnity contrac	t
	. □		, I ilwo donardot		11 0 doninadi	•		•
	m 📙	Other (specify)						
9	Evnari	ence-rated contracts:						
,	•	remiums: (1) Amount received		9a(1)				
		2) Increase (decrease) in amount due but unpaid						
	,	B) Increase (decrease) in unearned premium res						
		4) Earned ((1) + (2) - (3))				9a(4)		
	b E	Benefit charges (1) Claims paid		. 9b(1)	·			
	(2	2) Increase (decrease) in claim reserves		. 9b(2)				
	(3	B) Incurred claims (add (1) and (2))				9b(3)		
	•	1) Claims charged				9b(4)		
	C F	Remainder of premium: (1) Retention charges (o	n an accrual basis)	[
		(A) Commissions						
		(B) Administrative service or other fees		2 (4)(2)				
		(C) Other specific acquisition costs		0 (4)(D)				
		(D) Other expenses(E) Taxes		0-(4)(5)				
		(F) Charges for risks or other contingencies						
		(G) Other retention charges		0 (4)(0)				
		(H) Total retention				9c(1)(H)		
	(2	2) Dividends or retroactive rate refunds. (These	amounts were paid i	n cash, or	credited.)	9c(2)		
	d 8	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)		
		Dividends or retroactive rate refunds due. (Do no	ot include amount entere	d in line 9c(2).)	9e		
10		experience-rated contracts:			Г			
	_	otal premiums or subscription charges paid to c				10a		54910
	r	f the carrier, service, or other organization incurr etention of the contract or policy, other than report fy nature of costs.	, .		•	10b		
P	art IV	Provision of Information					1	
11	Did t	he insurance company fail to provide any inform	ation necessary to comp	lete Schedule	A? Y	es X	No	
12	If the	e 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

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File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2018

		pursuant to El	RISA section 103(a)(2).			110 1 011	Inspection	
For calendar plan year 20	18 or fiscal plar	year beginning 04/01/2018		and en	ding 04/0	1/2019		
A Name of plan F&E AIRCRAFT MAINTE	NANCE (MIAM	I) LLC		B Three-digit plan number (PN) 501				
C Plan sponsor's name a F&E AIRCRAFT MAINTE					yer Identifica 2177585	ation Number (EIN)	
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca UNITED OF OMAHA LIFE		COMPANY						
ALL FINI	(c) NAIC	(d) Contract or	(e) Approximate nur			Policy or co	ontract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To	
47-0322111	69868	G000AZTD	141	141 0			04/01/2019	
2 Insurance fee and come descending order of the		ation. Enter the total fees and tota	I commissions paid. Lis	st in line 3	the agents,	brokers, and ot	her persons in	
(a) Total a	amount of comr	nissions paid 6357		(b) To	otal amount	of fees paid		
3 Persons receiving com		ees. (Complete as many entries a						
LILIDCON CLIODE CDOLLE		nd address of the agent, broker, o		n commiss	ions or fees	were paid		
HUDSON SHORE GROUP		SUITE 3	ST FRONT STREET 110 .NK, NJ 07701					
(b) Amount of sales ar	nd base	Fees	and other commissions	s paid				
commissions pai		(c) Amount	(d) Purpose				(e) Organization code	
							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 commission	s paid				
commissions pai		(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	
			(5)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
, ,			
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
·			
(a) Na			
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(4) - 3-1-2-3	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
	•	Fees and other commissions paid	
(b) Amount of sales and base		·	(e) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
		·	Organization

Part II		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		ooguioition or	6d	_				
		retention of the contract or policy, enter amount.			<u> </u>					
		Specify nature of costs								
	е	Type of contract: (1) individual policies (2) group deferred	d annuity							
		(3) other (specify)								
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	ating plan, checl	k here						
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separ	ate accounts)						
	а	Type of contract: (1) deposit administration (2) immedia	ite participation g	juarantee						
		(3) guaranteed investment (4) other								
		_								
	b	Balance at the end of the previous year			7b	_				
	С	Additions: (1) Contributions deposited during the year	. 7c(1)							
		(2) Dividends and credits	7c(2)							
		(3) Interest credited during the year	7c(3)							
		(4) Transferred from separate account	. 7c(4)							
		(5) Other (specify below)	. 7c(5)							
		•								
		(6)Total additions			′c(6)					
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d					
		Deductions:	- (4)							
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)							
		(2) Administration charge made by carrier	7e(2)							
		(3) Transferred to separate account	7e(3) 7e(4)							
		(4) Other (specify below)	. /e(4)							
		•								
					(5)					
		(5) Total deductions			'e(5)					
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	_				

Part II		Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the the information may be combined for reporting purposes if such contracts are experience-rated as a unit. We employees, the entire group of such individual contracts with each carrier may be treated as a unit for purpose.									it. Where o	contract	ts cover individual
Ω	Bone	ofit o	nd contract type (check all applicable boxes)		Onti	acis with e	aciic	amer ma	y De	treated as a drift for p	uiposes oi	11113 10	port.
U		-	, , , , , , , ,		٦.	\t-1			<u>. </u>	1 ./:-:		⊿ □	Life income
	a	=	ealth (other than dental or vision)	b [ental				Vision		d∐	Life insurance
	е] Te	emporary disability (accident and sickness)	T L	╛┖	ong-term d	isabili	ty	g	Supplemental unem	nployment	h∐	Prescription drug
	i L	St	op loss (large deductible)	j	Н	IMO contra	ct		k _	PPO contract		I	Indemnity contract
	m	(O	ther (specify) VOLUNTARY LIFE INSURA	NCE									
9	Expe	rien	ce-rated contracts:										
	•		niums: (1) Amount received					9a(1)				
		(2) I	ncrease (decrease) in amount due but unpai	b					_				
			ncrease (decrease) in unearned premium res)				
		(4) E	Earned ((1) + (2) - (3))								9a(4)		
	b	Ben	efit charges (1) Claims paid					9b(1)				
		(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 (n an	acc	rual basis)		Г					
			(A) Commissions						_				
			(B) Administrative service or other fees										
			(C) Other specific acquisition costs										
			(D) Other expenses										
			(E) Taxes										
			(F) Charges for risks or other contingencies.					90(1)(F)				
			(G) Other retention charges								0.(4)(1		
			(H) Total retention			_			_			1)	
			Dividends or retroactive rate refunds. (These			L-1			ш				
	d		tus of policyholder reserves at end of year: (1										
		` '	Claim reserves								· · · · ·		
		` '	Other reserves								` '		
4.0			dends or retroactive rate refunds due. (Do n	ot inc	clude	e amount e	ntere	d in line 9	e(2).	.)	9e		
10			perience-rated contracts:								40		
	_		al premiums or subscription charges paid to o								<u>10a</u>		63572
	_	rete	e carrier, service, or other organization incur ntion of the contract or policy, other than rep nature of costs.								10b		
		cify r	nature of costs.					., .,					
P	art I	V	Provision of Information										
11	Dic	the	insurance company fail to provide any inform	nation	n ne	cessary to	comp	lete Sche	dule	A?	Yes	X N	0
12	! If th	ne ai	nswer to line 11 is "Yes," specify the informat	ion n	ot p	rovided.							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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OMB No. 1210-0110

2018

			RISA section 103(a)(2).	imomnade	J11	Inis For	m is Open to Public Inspection			
For calendar plan year 20	18 or fiscal pla	n year beginning 04/01/2018		and end	ling 04/0	1/2019				
A Name of plan F&E AIRCRAFT MAINTE	NANCE (MIAN	/II) LLC	E	B Three-digit plan number (PN) 501						
C Plan sponsor's name a F&E AIRCRAFT MAINTE					er Identifica 177585	ation 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		DBA EYEMED								
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate numl persons covered at e		(f)	Policy or c	ontract year (g) To			
43-0949844	71870	10057831001	policy or contract ye		04/01/2018		04/01/2019			
40 0040044	7 1070	10037031001	343	04/01/2018			04/01/2013			
descending order of the	amount paid.	ation. Enter the total fees and total	I commissions paid. List				ther persons in			
(a) Total amount of commissions paid (b) Total amount of fees paid 500533										
		300333								
3 Persons receiving com		ees. (Complete as many entries a								
HUDSON SHORE GROUP		and address of the agent, broker, o	or other person to whom o ST FRONT STREET	commissio	ons or fees	were paid				
TIODSON SHOKE GROOT		SUITE 3								
(b) Amount of sales ar			and other commissions							
commissions pa	d	(c) Amount	(d)		(e) Organization code					
							3			
	(a) Name a	and address of the agent, broker, o	or other person to whom o	commissio	ons or fees	were paid				
			·			·				
(b) Amount of sales ar	nd base	Fees	and other commissions	paid						
commissions pa		(c) Amount	(d)		(e) Organization code					
For Panerwork Reduction	n Act Notice	see the Instructions for Form 55	500			Scho	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	
			(5)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
, ,			
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
·			
(a) Na			
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(4) - 3-1-2-3	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
	•	Fees and other commissions paid	
(b) Amount of sales and base		·	(e) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
		·	Organization

Part II		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		ooguioition or	6d	_				
		retention of the contract or policy, enter amount.			<u> </u>					
		Specify nature of costs								
	е	Type of contract: (1) individual policies (2) group deferred	d annuity							
		(3) other (specify)								
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	ating plan, checl	k here						
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separ	ate accounts)						
	а	Type of contract: (1) deposit administration (2) immedia	ite participation g	juarantee						
		(3) guaranteed investment (4) other								
		_								
	b	Balance at the end of the previous year			7b	_				
	С	Additions: (1) Contributions deposited during the year	. 7c(1)							
		(2) Dividends and credits	7c(2)							
		(3) Interest credited during the year	7c(3)							
		(4) Transferred from separate account	. 7c(4)							
		(5) Other (specify below)	. 7c(5)							
		•								
		(6)Total additions			′c(6)					
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d					
		Deductions:	- (4)							
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)							
		(2) Administration charge made by carrier	7e(2)							
		(3) Transferred to separate account	7e(3) 7e(4)							
		(4) Other (specify below)	. /e(4)							
		•								
					(5)					
		(5) Total deductions			'e(5)					
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	_				

Р	art II		Welfare Benefit Contract Informa									
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ing p	urp	oses if such con	tracts are	expe	rience-rated as a unit	. Where c	ontrac	ts cover individual
8	Benef	fit ar	nd contract type (check all applicable boxes)									
	а	He	alth (other than dental or vision)	b		ental		CX	Vision		d	Life insurance
	е \Box	Te	mporary disability (accident and sickness)	f	ĪL	ong-term disabil	ity	gΠ	Supplemental unemp	oloyment	h∏	Prescription drug
	iΪ		pp loss (large deductible)	ιĖ	=	IMO contract	,		PPO contract	,	ıH	Indemnity contract
	. H			, [┙.	iivio contract		'\ _	110 contract		.⊓	macming contract
	m	Ot	her (specify)									
9		iono	a rated contractor									
9	•		e-rated contracts: iums: (1) Amount received				02/1	<u>, </u>				
			ncrease (decrease) in amount due but unpaid									
	,	,	ncrease (decrease) in amount due but unpaid ncrease (decrease) in unearned premium res					_				
			arned ((1) + (2) - (3))					-		9a(4)		
	_ `	,	efit charges (1) Claims paid							σα(.)		
			ncrease (decrease) in claim reserves				/-	_				
	,	,	ncurred claims (add (1) and (2))							9b(3)		
	•	,	laims charged							9b(4)		
	C	, Rem	nainder of premium: (1) Retention charges (c	n an	acc	rual basis)				• • •		
		(A) Commissions				9c(1)(A)				
		(B) Administrative service or other fees				. 9c(1)(B)				
		(C) Other specific acquisition costs									
		(D) Other expenses									
		,	E) Taxes									
			F) Charges for risks or other contingencies				A (4) (
		,	G) Other retention charges							0. (4)(1)		
		,	H) Total retention			_				9c(1)(H)	
			Dividends or retroactive rate refunds. (These							9c(2)		
			us of policyholder reserves at end of year: (1	•		•				9d(1)		_
		,	Claim reserves							9d(2)		
		` '	Other reserves							9d(3)		
10			dends or retroactive rate refunds due. (Do nerience-rated contracts:	ot inc	iuu	e amount entere	a in line s	9C(2).)	9e		
10			enence-rated contracts. I premiums or subscription charges paid to c	arria	r					10a		50964
	_									IVa		30904
	ı	eter	e carrier, service, or other organization incurnation of the contract or policy, other than repeature of costs.		•	•			•	10b		
	Spec	iiy n	ature of costs.									
P	art I\	/	Provision of Information									
11	Did	the i	insurance company fail to provide any inform	atior	n ne	cessary to comr	lete Sche	edule	А?	Yes	Пи	0
			swer to line 11 is "Yes," specify the informat								Ш	
12	n ule	ا ال	swer to line it is ites, specify the illioffilat	OH H	σι μ	TOVIUGU. F						



May 10, 2019

F&E AIRCRAFT MAINTENANCE MIAMI LLC 657 SOUTH DR STE 306 MIAMI SPRINGS, FL 33166

Re: Certified Information for Department of Labor

Form 5500, Schedule A

Group Number(s): GLTD0AZTD

GLUG0AZTD GUC 0AZTD **GUDE0AZTD GUDH0AZTD** GUG 0AZTD **GUPROAZTD GVTL0AZTD**

Thank you for choosing Mutual of Omaha as your group insurance carrier. We appreciate the opportunity to service you and your employees. Attached, you'll find the Form 5500, Schedule A.

I certify that the attached information for the Form 5500, Schedule A, Part I and Part III, has been taken from our company records and is correct to the best of my knowledge. Mutual of Omaha is providing you with the attached information but makes no representation regarding reporting requirements. Please consult your attorney or other advisor as to your reporting obligations.

For questions, please contact your dedicated Customer Service team or call 1-800-655-5142.

Sincerely,

James Davenport Senior Vice President Finance Operations

F&E AIRCRAFT MAINTENANCE MIAMI LLC MIAMI SPRINGS, FL

United of Omaha Life Insurance Company - NAIC Code 69868 Name of Carrier:

EIN Number: **Group Identification** 47-0322111 G000AZTD

Data for Period: 04-01-2018 to 04-01-2019

Number:

Legacy Group ID: **Type of Contract:**

GLTD0AZTD NON-RETENTION

Benefits Provided

Persons Covered

Long Term Disability Insured

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
HUDSON SHORE GROUP INC 141 W FRONT ST RED BANK, NJ 07701	2,603		Agent or Broker of Record	3
	INFORMATION FO	OR COMPLETION OF PAI	RT III	

10. Non-experience Rated Contracts:

26,034

0

Administrative Service Fees 0

F&E AIRCRAFT MAINTENANCE MIAMI LLC MIAMI SPRINGS, FL

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868

EIN Number: Group Identification 47-0322111 G000AZTD

Group Identification Number:

G000AZ1D

Data for Period: 04-01-2018 to 04-01-2019

Legacy Group ID: Type of Contract: GLUG0AZTD NON-RETENTION

Benefits Provided

Persons Covered

Belletits 110 (lucu	i ci sons covered
Life & AD&D	562

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
HUDSON SHORE GROUP INC 141 W FRONT ST RED BANK, NJ 07701	9,688		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Administrative Service Fees 0

F&E AIRCRAFT MAINTENANCE MIAMI LLC MIAMI SPRINGS, FL

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868

EIN Number: Group Identification 47-0322111

G000AZTD

Data for Period: 04-01-2018 to 04-01-2019

Number:

RED BANK, NJ 07701

Legacy Group ID: Type of Contract:

GUC 0AZTD NON-RETENTION

Benefits Provided Persons Covered

ShortTerm Disability Voluntary

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
HUDSON SHORE GROUP INC 141 W FRONT ST	9,046		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

90,457

17,890

Administrative Service Fees

F&E AIRCRAFT MAINTENANCE MIAMI LLC MIAMI SPRINGS, FL

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868

EIN Number: Group Identification 47-0322111

G000AZTD

Data for Period: 04-01-2018 to 04-01-2019

Number:

Legacy Group ID: Type of Contract:

GUDE0AZTD NON-RETENTION

Benefits Provided

Persons Covered

Critical Illness Voluntary

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
HUDSON SHORE GROUP INC 141 W FRONT ST RED BANK, NJ 07701	2,388		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

23,876

10,000

Administrative Service Fees

F&E AIRCRAFT MAINTENANCE MIAMI LLC MIAMI SPRINGS, FL

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868

EIN Number: Group Identification 47-0322111

G000AZTD

Data for Period: 04-01-2018 to 04-01-2019

Number:

Legacy Group ID: Type of Contract:

GUDH0AZTD NON-RETENTION

Benefits Provided Persons Covered

Accident only Voluntary

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
HUDSON SHORE GROUP INC 141 W FRONT ST RED BANK, NJ 07701	5,142		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

51,420

4,650

Administrative Service Fees 0

F&E AIRCRAFT MAINTENANCE MIAMI LLC MIAMI SPRINGS, FL

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868

EIN Number: Group Identification Number:

47-0322111

G000AZTD

GUG 0AZTD

Legacy Group ID: Type of Contract:

NON-RETENTION

Benefits Provided Persons Covered

Short Term Disability Insured

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
HUDSON SHORE GROUP INC 141 W FRONT ST RED BANK, NJ 07701	2,354		Agent or Broker of Record	3

Data for Period: 04-01-2018 to 04-01-2019

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

23,538

0

0 Administrative Service Fees

F&E AIRCRAFT MAINTENANCE MIAMI LLC MIAMI SPRINGS, FL

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868

EIN Number:

47-0322111 G000AZTD

Data for Period: 04-01-2018 to 04-01-2019

Group Identification

Number: **Legacy Group ID:**

GUPR0AZTD NON-RETENTION

Type of Contract: Benefits Provided

Persons Covered

Long Term Disability Voluntary

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
HUDSON SHORE GROUP INC 141 W FRONT ST RED BANK, NJ 07701	5,491		Agent or Broker of Record	3
	INFORMATION FO	OR COMPLETION OF PA	RT III	

10. Non-experience Rated Contracts:

54,910

0

0 Administrative Service Fees

F&E AIRCRAFT MAINTENANCE MIAMI LLC MIAMI SPRINGS, FL

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868

EIN Number: Group Identification 47-0322111

G000AZTD

Data for Period: 04-01-2018 to 04-01-2019

Number:

GVTL0AZTD **Legacy Group ID: Type of Contract:** NON-RETENTION

Benefits Provided

Persons Covered

Term Life - Voluntary

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
HUDSON SHORE GROUP INC 141 W FRONT ST RED BANK, NJ 07701	6,357		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

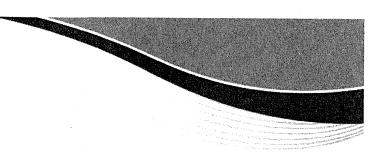
63,572

100,000

Administrative Service Fees



Financial Special Services PO Box 1087 Wausau, WI 54402-1087



42093

F&E AIRCRAFT MAINTENANCE (MIAMI), LLC GUY TICKNER 657 SOUTH DR STE 306 MIAMI SPRINGS FL 33166

May 9, 2019

Enclosed please find a summary of financial information regarding your self-funded group health plan administered by UMR. Part I of the summary lists the fees charged by our company to administer your benefit plan (Service Provider Administrative Expenses.) In addition, if we paid a commission in connection with your plan that information would also be disclosed in Part I of the summary.

Your plan may be subject to the federal reporting requirements found in the Employee Retirement Income Security Act (ERISA). You and your advisor will determine if you are subject to ERISA based on whether the plan sponsor is a private sector company, state or local government, or a church. As a general rule, private sector plans that cover 100 or more participants are required to comply with ERISA's reporting requirements, commonly known as the Form 5500. State and local governments and most churches are generally exempt from these reporting requirements.

If your plan is subject to ERISA, you will want to forward the enclosed Part I information to the individual who prepares your organization's Form 5500 to assist them in completing the form.

Part II of the summary lists commissions paid in connection with the placement of stop loss coverage. Stop loss coverage is normally a policy purchased by an employer to help manage the risks associated with a self-funded group health plan. Except in the case of extraordinary plan designs, stop loss is not reportable on the ERISA Form 5500. The instructions to the Form 5500, explain that stop loss policies are not assets of the plan and stop loss information is not reportable on the Form 5500.

Basic information about ERISA's filing requirements, including the Form 5500 filing instructions, can be obtained from the US Department of Labor's web site, http://www.dol.gov/ebsa/. If you have questions about your filing obligations under applicable law, you should consult with your legal counsel. If you have questions about the summary financial information enclosed in this letter, contact your UMR account representative.

We strive to make certain that our customers understand how their valuable health care dollars are spent. We value your business and trust that this information will be helpful to you.

Joseph Gulley

Director of Financial Operations

Schedule C Reporting

The information provided below is furnished to the contract holder to assist it in fulfilling its annual Form 5500 reporting obligation.

Name of Contract holder: Contract Number: Data for Period Beginning: Data for Period Ending:	76412400	General Informati MAINTENANCE (MIAMI), LLC	t it in fulfilling its annual Form 55	and in
---	----------	---	---------------------------------------	--------

2(a) Name - I Till	cooling Direct or Indirect Companyation
Form 5500 Schedule C Part I, Line 2 Information on Service I Form 5500 Part I Line 2 2(a) Name and EIN	Response
	UMR, Inc.
P(b) Service Code(s)	39-1995276
(c) Relationship to Employer	12
(d) Direct compensation paid by the	Claims Processing
(c) was any indirect compensation	\$239,347.74
(i) vas any multer component	Yes
g) Enter total indirect company to	No
h) Is a formula being provided in lieu of/in addition to 2(g)?	\$727.88
prm 5500 Part I Line 2	No

Form 5500 Part I Line 2	No
2(a) Name, Address, and EIN	Response
	HUDSON SHORE GROUP INC
2(b) Service Code(s)	141 West Front Street, Suite 310, RED BANK, NJ 07701 27-3738076
2(c) Relationship to Employer	55
2(d) Direct compensation paid by the	Broker
Z(e) was any indirect compensation	\$157,836.00
-(i) vvas any muliect compensation Floo	No
L=(g) Enter total indirect component	No
2(h) Is a formula being provided in lieu of/in addition to 2(g)?	\$0.00
	No
For plans subject to ERISA's reporting requirements, the above informa-	

For plans subject to ERISA's reporting requirements, the above information may be used for purposes of the Schedule C.

Insurance Information

The information provided below is furnished to the contract holder to assist it in fulfilling its annual Form 5500 reporting obligation.

Name of Contract holder:	F&E AIRCRAFT MAINTENANCE (MIAMI), LLC
Form 5500 Line 1	Response.
(a) Name of Insurance Carrier:	United Healthcare Insurance Company
(b) EIN:	36-2739571

United Healthcare Insurance Company
36-2739571
79413
417003412469
329
4/1/2018
4/1/2019

Benefit/Contract Type (Health, Dental, Vision, Life, STD, LTD, Rx, SL, Other): Stop Loss Form 5500 Line 9 or 10	Form 5500 Line 8	Response
Form 5500 Line 9 or 10	Benefit/Contract Type (Health, Dental, Vision, Life, STD, LTD, Rx, SL, Other):	Ston Loss
	Form 5500 Line 9 or 10	Response
(a) Total premiums or subscription charges paid to carrier: \$691,073.85	(a) Total premiums or subscription charges paid to carrier:	

Except for extraordinary plan designs, stop loss policies are not ERISA policies and premiums and/or commissions are not subject to reporting on the ERISA Form 5500. It is possible that additional compensation based on production or persistency may be received in connection with the placement of the stop loss policy. Contact your account representative if you would like an estimate of these contingent amounts.

June 12, 2019

F000050000002000001000J1KNERE*350F

*000050*J1KNERE*000131*

Important Document Enclosed LEE DOA AND 331 19956 1 AB 0.412

F&E AIRCRAFT MAINTENANCE(MIAMI), LLC **GUY TICKNER** 657 SOUTH DRIVE, SUITE 306 MIAMI SPRINGS FL 33166-5926

րիկիրիդիդիդիկիլիդիկիիոկիկիկիկիկինի

Re: Annual Reporting Under Employee Retirement Income Security Act of 1974 (ERISA)

55

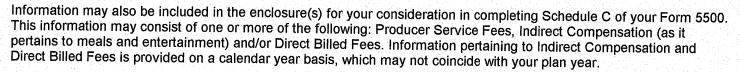
For: F&E AIRCRAFT MAINTENANCE(MIAMI), LLC

0773068

Policy Period: April 01, 2018 through March 31, 2019

We have enclosed information for your policy period listed above to help you complete the Schedule A to ERISA Form 5500 Annual Report. We are providing this information in accordance with U.S. Department of Labor regulations.

Note that compliance with the ERISA requirements for completion of the Annual Report and its filing with the Internal Revenue Service is the sole responsibility of employers, plan administrators and their professional advisors. Aetna Life Insurance Co. cannot and does not assume any responsibility for such compliance, but we are pleased to provide information pertaining to your insurance program as needed to complete the Report.



If you have other benefits plans with Aetna Life Insurance Co., you may receive additional ERISA information to complete your Schedule A and Schedule C for those plans under separate cover.

If you have any additional reporting needs, please contact your Aetna Life Insurance Co. account manager, or call 1-800-818-0691 to speak with the ERISA support team.

Sincerely,

Aetna Life Insurance Co.

Enclosure

INSURANCE INFORMATION AETNA LIFE INSURANCE COMPANY AND AFFILIATES

The following information is intended for your use in completing Schedule A of Form 5500.

			4 1 L 1 4/	ANCE(MIAMI), LLC		
1 Coverage Tradition	on Concerning Insuranc	e Contract Coverage, F	ees, and	Commissions.		
Coverage: Traditio Name of Insurance						
Aetna Life Insuranc	(d) Contract Number or Identification:	(e) App	proximate Number of sons covered at the end	Policy or contract Year		
		of p	olicy or contract year:			
c) NAIC Code: See /	AIC Code: See Attached Listing 724		(f) From:	(g)To:		
	d commissions paid to a	gents and brokers		724	04/01/2018	03/31/2019
Contract or			'oro	4.		
Identification	cation to the address of the agents of brokers (b) Amount of		commissions paid	(c) & (d) Fees Paid	
773068	HUDSON SHORE O STREET SUITE 31	BROUP INC 141 W FR 0 RED BANK NJ 077	ONT 701-642	\$9,258.83	Amount	Purpose
				\$9,258.83		
TOTAL	 In the control of the c		and the second of			
			nay be	attributed to multiple A	etna companies.	
art III Welfare B If more than one information may be entire group of such Benefit and contract the Health (other than de Temporary disability Stop loss (large deduction)	enefit Contract In contract covers the sale combined for reporting ch individual contracts we type (check all applicable ental or vision) (accident and sickness) uctible)	formation me group of employees g purposes if such cor ith each carrier may be boxes) Dental Long-term disa	s of the ntracts a treated a		nbers of the same emunit. Where individual sireport.	contracts are provide Life Insurance Prescription drug
If more than one information may be entire group of such Benefit and contract the Health (other than de Temporary disability Stop loss (large ded Accidental Death & E	enefit Contract In contract covers the same combined for reporting the individual contracts we type (check all applicable ental or vision) (accident and sickness) suctible)	formation me group of employees g purposes if such cor ith each carrier may be boxes) Dental Long-term disa	s of the ntracts a treated a	same employer(s) or men re experience-rated as a use a unit for purposes of this Vision Supplemental uner	nbers of the same emunit. Where individual sireport.	contracts are provide
If more than one information may be entire group of such entire e	enefit Contract In contract covers the sal be combined for reportin ch individual contracts w type (check all applicable ental or vision) (accident and sickness) uctible) Dismemberment tracts: NA	formation me group of employees g purposes if such cor ith each carrier may be boxes) Dental Long-term disa	s of the ntracts a treated a	same employer(s) or men re experience-rated as a use a unit for purposes of this Vision Supplemental uner	nbers of the same emunit. Where individual sireport.	contracts are provide Life Insurance Prescription drug
If more than one information may be entire group of such entire group of	enefit Contract In contract covers the sal be combined for reportin ch individual contracts w type (check all applicable ental or vision) (accident and sickness) uctible) Dismemberment tracts: NA contracts:	formation me group of employees g purposes if such cor ith each carrier may be boxes) X Dental Long-term disa HMO contract Short Term Dis	s of the ntracts a treated a	same employer(s) or men re experience-rated as a use a unit for purposes of this Vision Supplemental uner	nbers of the same emunit. Where individual sireport.	contracts are provide Life Insurance Prescription drug
If III Welfare B If more than one information may be entire group of such a suc	enefit Contract In contract covers the sal be combined for reportin ch individual contracts w type (check all applicable ental or vision) (accident and sickness) uctible) Dismemberment tracts: NA contracts: or subscription charges rvice or other organizatic contract or policy, other t	formation me group of employees g purposes if such cor ith each carrier may be boxes) X Dental Long-term disa HMO contract Short Term Dis	s of the ntracts a treated a ability	same employer(s) or men re experience-rated as a use a unit for purposes of this Vision Supplemental uner	nbers of the same emunit. Where individual is report.	contracts are provide Life Insurance Prescription drug
If more than one information may be entire group of such entire e	enefit Contract In contract covers the sale combined for reportin ch individual contracts w type (check all applicable ental or vision) (accident and sickness) uctible) Dismemberment tracts: NA contracts: or subscription charges rvice or other organizatio contract or policy, other to	formation me group of employees g purposes if such cor ith each carrier may be boxes) X	s of the ntracts a treated a ability	attributed to multiple A	nbers of the same emunit. Where individual is report.	contracts are provide Life Insurance Prescription drug Indemnity contract
If more than one information may be entire group of such entire e	enefit Contract In contract covers the sale combined for reportin ch individual contracts w type (check all applicable ental or vision) (accident and sickness) uctible) Dismemberment tracts: NA contracts: or subscription charges rvice or other organizatio contract or policy, other to f costs> erated as of 05/31/2019	formation me group of employees g purposes if such cor ith each carrier may be boxes) Dental Long-term disa HMO contract Short Term Dis paid to carrier	s of the ntracts a treated a ability	attributed to multiple A	nbers of the same emunit. Where individual is report. Inployment	contracts are provide Life Insurance Prescription drug Indemnity contract \$258,651.67
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John Stenson, VP Corp Accounting AETNA LIFE INSURANCE COMPANY AND AFFILIATES

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Vision Insurance Information For Form 5500

Information Compiled By: EyeMed Vision Care on behalf of the Fidelity Security Life Insurance Company

Report Start Date	Report End Date			
4/1/2018	3/31/2019			

Payments Received by carrier from plan or plan sponsor:

Name of Plan	Contract or ID #	Enrollment Group	Approximate number of persons covered at end of policy or contract year:	EIN	NAIC		Amount
F & E AIRCRAFT MAINTENANCE LLC	10057831001	F&E AIRCRAFT MAINTENANCE, LLC	535	430949844	71870		\$50,332.41
F & E AIRCRAFT MAINTENANCE LLC	10057831002	F&E AIRCRAFT EXEC	10	430949844	71870		\$631.68
545						Total:	\$50,964.09

Commissions or fees paid by carrier to agents, brokers or other persons:

Payee Name	Address Line 1	City	State	Zip Code	Commisssion Type Code	Amount
Hudson Shore Group	141 W. Front Street, STE 310	Red Bank	NJ	07701-6421	COMM	\$5,005.33

