

Form 5500-SF Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Short Form Annual Return/Report of Small Employee Benefit Plan This form is required to be filed 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-SF.	OMB Nos. 1210-0110 1210-0089 <div style="border: 1px solid black; text-align: center; padding: 5px; font-weight: bold; font-size: 1.2em;">2019</div> This Form is Open to Public Inspection
---	--	---

Part I Annual Report Identification Information	
For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019	
A This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) <input type="checkbox"/> a one-participant plan <input type="checkbox"/> a foreign plan
B This return/report is	<input type="checkbox"/> the first return/report <input checked="" type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C Check box if filing under:	<input type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)

Part II Basic Plan Information —enter all requested information													
1a Name of plan SHIPP EYE CLINIC, P.C. 401(K) PROFIT SHARING PLAN	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">1b Three-digit plan number (PN) ►</td> <td style="width: 40%; text-align: center; color: blue;">002</td> </tr> <tr> <td colspan="2">1c Effective date of plan 10/01/1978</td> </tr> </table>	1b Three-digit plan number (PN) ►	002	1c Effective date of plan 10/01/1978									
1b Three-digit plan number (PN) ►	002												
1c Effective date of plan 10/01/1978													
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) SHIPP EYE CLINIC, P.C. 3302 C. WEST LINDEN CORINTH, MS 38834-9119	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) 20-2926095</td> </tr> <tr> <td>2c Sponsor's telephone number 662-286-6068</td> </tr> <tr> <td>2d Business code (see instructions) 621111</td> </tr> </table>	2b Employer Identification Number (EIN) 20-2926095	2c Sponsor's telephone number 662-286-6068	2d Business code (see instructions) 621111									
2b Employer Identification Number (EIN) 20-2926095													
2c Sponsor's telephone number 662-286-6068													
2d Business code (see instructions) 621111													
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>3b Administrator's EIN</td> </tr> <tr> <td>3c Administrator's telephone number</td> </tr> </table>	3b Administrator's EIN	3c Administrator's telephone number										
3b Administrator's EIN													
3c Administrator's telephone number													
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>4b EIN</td> </tr> <tr> <td>4d PN</td> </tr> </table>	4b EIN	4d PN										
4b EIN													
4d PN													
5a Total number of participants at the beginning of the plan year	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">5a</td> <td style="width: 40%; text-align: center; color: blue;">12</td> </tr> <tr> <td>5b Total number of participants at the end of the plan year</td> <td style="text-align: center; color: blue;">0</td> </tr> <tr> <td>5c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)</td> <td style="text-align: center; color: blue;">0</td> </tr> <tr> <td>5d(1) Total number of active participants at the beginning of the plan year</td> <td style="text-align: center; color: blue;">11</td> </tr> <tr> <td>5d(2) Total number of active participants at the end of the plan year</td> <td style="text-align: center; color: blue;">0</td> </tr> <tr> <td>5e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested</td> <td style="text-align: center; color: blue;">0</td> </tr> </table>	5a	12	5b Total number of participants at the end of the plan year	0	5c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	0	5d(1) Total number of active participants at the beginning of the plan year	11	5d(2) Total number of active participants at the end of the plan year	0	5e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	0
5a	12												
5b Total number of participants at the end of the plan year	0												
5c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	0												
5d(1) Total number of active participants at the beginning of the plan year	11												
5d(2) Total number of active participants at the end of the plan year	0												
5e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	0												

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
 Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	04/15/2020	BERNARD SHIPP
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	04/15/2020	BERNARD SHIPP
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) ☒ Yes ☐ No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) ☒ Yes ☐ No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ☐ Yes ☐ No ☐ Not determined
- If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	4586363	0
b Total plan liabilities	7b		0
c Net plan assets (subtract line 7b from line 7a)	7c	4586363	0
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	6712	
(2) Participants	8a(2)	13653	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	562927	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		583292
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	5160612	
e Certain deemed and/or corrective distributions (see instructions) ...	8e		
f Administrative service providers (salaries, fees, commissions)	8f	9043	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		5169655
i Net income (loss) (subtract line 8h from line 8c)	8i		-4586363
j Transfers to (from) the plan (see instructions)	8j		

Part IV Plan Characteristics

- 9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2E 3D 2J 2K
- b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part V Compliance Questions

10 During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c	X		500000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X	
f Has the plan failed to provide any benefit when due under the plan?	10f		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		X	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X	
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i			

Part VI Pension Funding Compliance

11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 12 below..... ☐ Yes ☒ No

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 **11a**

b PBGC missed contribution reporting requirements. If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

- ☐ Yes.
- ☐ No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
- ☐ No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
- ☐ No. Other. Provide explanation _____

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ☐ Yes ☒ No
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above.

a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. Month _____ Day _____ Year _____

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

b Enter the minimum required contribution for this plan year **12b**

c Enter the amount contributed by the employer to the plan for this plan year **12c**

d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount) **12d**

e Will the minimum funding amount reported on line 12d be met by the funding deadline? ☐ Yes ☐ No ☐ N/A

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year? ☒ Yes ☐ No

If "Yes," enter the amount of any plan assets that reverted to the employer this year..... **13a** 0

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? ☒ Yes ☐ No

c If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

Form 5500-SF Department of the Treasury Internal Revenue Service	Short Form Annual Return/Report of Small Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ► Complete all entries in accordance with the instructions to the Form 5500-SF.	OMB Nos. 1210-0110 1210-0089 <div style="border: 1px solid black; padding: 5px; text-align: center;"> 2019 </div> This Form is Open to Public Inspection
---	---	---

Part I Annual Report Identification Information			
For calendar plan year 2019 or fiscal plan year beginning		01/01/2019	and ending 12/31/2019
A	This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)	
B	This return/report is:	<input type="checkbox"/> a one-participant plan <input type="checkbox"/> a foreign plan <input type="checkbox"/> the first return/report <input checked="" type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)	
C	Check box if filing under:	<input type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)	

Part II Basic Plan Information --- enter all requested information			
1a	Name of plan Shipp Eye Clinic, P.C. 401(k) Profit Sharing Plan	1b	Three-digit plan number (PN) ► 002
		1c	Effective date of plan 10/01/1978
2a	Plan sponsor's name (employer, if for a single-employer plan) Mailing Address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Shipp Eye Clinic, P.C. 3302 C. West Linden US Corinth MS 38834-9119	2b	Employer Identification Number (EIN) 20-2926095
		2c	Sponsor's telephone number (662) 286-6068
		2d	Business code (see instructions) 621111
3a	Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b	Administrator's EIN
		3c	Administrator's telephone number
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name	4b	EIN
		4d	PN
5a	Total number of participants at the beginning of the plan year	5a	12
b	Total number of participants at the end of the plan year	5b	0
c	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	5c	0
d(1)	Total number of active participants at the beginning of the plan year	5d(1)	11
d(2)	Total number of active participants at the end of the plan year	5d(2)	0
e	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	0

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

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	 Signature of plan administrator	4/15/20 Date	John Shipp Enter name of individual signing as plan administrator
SIGN HERE	 Signature of employer/plan sponsor	4/15/20 Date	John Shipp Enter name of individual signing as employer or plan sponsor

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) ☒ Yes ☐ No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) ☒ Yes ☐ No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ☐ Yes ☐ No ☐ Not determined
- If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this year (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	4,586,363	0
b Total plan liabilities	7b		0
c Net plan assets (subtract line 7b from line 7a)	7c	4,586,363	0
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	6,712	
(2) Participants	8a(2)	13,653	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	562,927	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		583,292
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	5,160,612	
e Certain deemed and/or corrective distributions (see instructions) ...	8e		
f Administrative service providers (salaries, fees, commissions)	8f	9,043	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		5,169,655
i Net income (loss) (subtract line 8h from line 8c)	8i		(4,586,363)
j Transfers to (from) the plan (see instructions)	8j		

Part IV Plan Characteristics

- 9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2E 3D 2J 2K
- b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part V Compliance Questions

10 During the plan year:		Yes	No	N/A	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X		
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X		
c Was the plan covered by a fidelity bond?	10c	X			500,000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X		
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X		
f Has the plan failed to provide any benefit when due under the plan?	10f		X		
g Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		X		
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X		
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i				

Part VI Pension Funding Compliance

11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 11 blank and complete line 12 below ☐ Yes ☒ No

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 **11a**

b PBGC missed contribution reporting requirements. If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

- ☐ Yes.
- ☐ No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
- ☐ No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
- ☐ No. Other. Provide explanation: _____

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ☐ Yes ☒ No
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above.

a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver Month Day Year

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

b Enter the minimum required contribution for this plan year.	12b	
c Enter the amount contributed by the employer to the plan for the plan year	12c	
d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	12d	
e Will the minimum funding amount reported on line 12d be met by the funding deadline?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year? ☒ Yes ☐ No
If "Yes," enter the amount of any plan assets that reverted to the employer this year **13a** 0

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? ☒ Yes ☐ No

c If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

SUMMARY ANNUAL REPORT
for
Shipp Eye Clinic, P.C. 401(k) Profit Sharing Plan

This is a summary of the annual report for Shipp Eye Clinic, P.C. 401(k) Profit Sharing Plan, 20-2926095/002 for 01/01/2019 through 12/31/2019. The annual report has been filed with the Employee Benefits Security Administration, formerly known as the Pension and Welfare Benefits Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

Plan expenses were \$5,169,655. These expenses included \$9,043 in administrative expenses, \$5,160,612 in benefits paid to participants and beneficiaries, and \$0 in other expenses. A total of 0 persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these persons had yet earned the right to receive benefits.

The value of plan assets, after subtracting liabilities of the plan was \$0 as of 12/31/2019 compared to \$4,586,363 as of 01/01/2019. During the plan year the plan experienced a decrease in its net assets of (\$4,586,363). This decrease includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of \$583,292, including employer contributions of \$6,712, employee contributions of \$13,653 and earnings from investments of \$562,927.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Shipp Eye Clinic, P.C., who is Plan Administrator at 3302 C. West Linden, Corinth MS 38834-9119, (662) 286-6068. The charge to cover copying cost will be \$3.00 for the full annual report, or \$1.50 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, if any, or a statement of income and expenses of the plan and accompanying notes, if any, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes, if any, will be included as part of that report. The charge to cover copying costs given above does not include a charge for copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan at 3302 C. West Linden, Corinth MS 38834-9119 and at the US Department of Labor in Washington DC, or obtain a copy from the US Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1515, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue, NW, Washington DC 20210.

E-SIGNATURE AUTHORIZATION

for

Shipp Eye Clinic, P.C. 401(k) Profit Sharing Plan

20-2926095/002

For Plan Year 01/01/2019 through 12/31/2019

I/We, the undersigned, understand that a 5500 Series filing for the plan listed above must be prepared, electronically signed and electronically transmitted to the EBSA Electronic Filing Acceptance System (EFAST).

I/We authorize Richard Bullock Jr., CPA to electronically sign the 5500 Series filing on my/our behalf and to transmit that signed form to EFAST on or before the filing due date.

I/We understand that by granting this authority:

- A manually signed and dated Form 5500-SF that has been provided must be returned to Richard Bullock Jr., CPA before they can begin the electronic filing process. I/We will retain a copy of this manually signed form and any schedules and attachments in the plan records.
 - Richard Bullock Jr., CPA will not be responsible for any late filing penalty assessed under ERISA should I/we not return the manually signed and dated Form 5500-SF prior to the filing due date.
- An electronic copy of the manually signed and dated Form 5500-SF showing my/our signatures will be included in the electronic filing and will be posted by the EBSA to the Internet for public disclosure.
- Richard Bullock Jr., CPA will maintain a copy of this written authorization in its records.
- Richard Bullock Jr., CPA will notify all signers about any inquiries and correspondence it receives about this filing from EFAST, EBSA, IRS or PBGC.
- Richard Bullock Jr., CPA shall not be deemed to be a plan fiduciary with respect to this plan solely on account of providing the electronic signature and filing of the 5500-SF for the plan year listed above.

Plan Administrator

Date

Plan Sponsor

Date