Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2019

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:
- ☐ a multiemployer plan
- ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
- ☒ a single-employer plan
- ☐ a DFE (specify) ____

B This return/report is:
- ☐ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ ☐

D Check box if filing under:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
HFS HOLDING CORPORATION

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/2013

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)
HFS HOLDING CORPORATION

8719 DIPLOMACY ROW
DALLAS, TX 75247-5401

8719 DIPLOMACY ROW
DALLAS, TX 75247-5401

2b Employer Identification Number (EIN)
75-1827504

2c Plan Sponsor's telephone number
214-634-8600

2d Business code (see instructions)
334610

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

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	07/09/2020	RACHAEL KING
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] 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

5	Total number of participants at the beginning of the plan year	**5**	155
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**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	155
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	205
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	205
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	205
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a 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:

4A 4B 4D 4F 4H 4L

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

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

a Pension Schedules

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 5 **A** (Insurance Information)
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

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.) ..... ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2019 Form M-1 annual report. If the plan was not required to file the 2019 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
HFS HOLDING CORPORATION

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
HFS HOLDING CORPORATION

D Employer Identification Number (EIN)
75-1827504

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	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
47-0322111	69868	G000BHHK	155	01/01/2019	01/01/2020

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
13588	0

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

BROADD REACH BENEFITS INC
30 COOK PLZ SUITE 200
PO BOX 545
MADISON, NJ 07940

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
13588			3

(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	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a 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 connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	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			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [X] Temporary disability (accident and sickness)
- **f** [X] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [X] Other (specify) ▶ VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	121271
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ..... [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
HFS HOLDING CORPORATION

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
HFS HOLDING CORPORATION

D Employer Identification Number (EIN)
75-1827504

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
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	5949232	205	01/01/2019	12/31/2019

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
6481	0

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

BROAD REACH BENEFITS INC
30 COOK PLZ SUITE 200
PO BOX 545
MADISON, NJ 07940

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
6481			3

(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	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a 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 connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	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			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** ☐ Health (other than dental or vision)
- **b** ☒ Dental
- **c** ☐ Vision
- **d** ☐ Life insurance
- **e** ☐ Temporary disability (accident and sickness)
- **f** ☐ Long-term disability
- **g** ☐ Supplemental unemployment
- **h** ☐ Prescription drug
- **i** ☐ Stop loss (large deductible)
- **j** ☐ HMO contract
- **k** ☐ PPO contract
- **l** ☐ Indemnity contract
- **m** ☐ Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	65130
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
HFS HOLDING CORPORATION

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
HFS HOLDING CORPORATION

D Employer Identification Number (EIN)
75-1827504

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
WESTPORT INSURANCE CORPORATION

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
48-0921045	39845	ESL 110025600	121	01/01/2019	12/31/2019

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
1970	0

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

BROAD REACH BENEFITS INC
30 COOK PLZ SUITE 200
PO BOX 545
MADISON, NJ 07940

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
492			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

INSURANCE GROUP OF AMERICA LLC
6640 CAROTHERS PARKWAY
SUITE 160
FRANKLIN, TN 37067

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
1477			3

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a 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 connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	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			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [X] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	19695
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ..... [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
HFS HOLDING CORPORATION

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
HFS HOLDING CORPORATION

D Employer Identification Number (EIN)
75-1827504

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
WESTPORT INSURANCE CORPORATION

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
48-0921045	39845	ESL 100092500	121	01/01/2019	12/31/2019

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
58336	

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

BROAD REACH BENEFITS INC
30 COOK PLZ SUITE 200
PO BOX 545
MADISON, NJ 07940

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
14584			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

INSURANCE GROUP OF AMERICA
6640 CAROTHERS PARKWAY
SUITE 160
FRANKLIN, TN 37067

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
43752			3

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a 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 connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	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			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [X] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	388906
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ..... [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
HFS HOLDING CORPORATION

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
HFS HOLDING CORPORATION

D Employer Identification Number (EIN)
75-1827504

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
AMERICAN HERITAGE LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
59-0781901	60534	27226	68	01/01/2021	12/31/2019

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
11529	

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

ALLISON A WISE
7142 LAGUNA VILLAS
HOUSTON, TX 77036

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

AYALA VANESSA
1790 RUSSELL LANE
SAN BENITO, TX 78586

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
31			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

USI SOUTHWEST INC

PO BOX 61187
VIRGINIA BEACH, VA 23466

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2222			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

BRANDON PENKO

4927 MAGNOLIA BEND DR
ROSHARON, TX 77583

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
199			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

DALLAS MORENO

6200 SAVOY DR
SUITE 345
HOUSTON, TX 77036

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
15			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

BRYAN INGLIS

104 PENNS WAY
SHAVANO PARK, TX 78231

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
150			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

MARIA GARCIA

7215 BOYCE ST
HOUSTON, VI 77020

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
28			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

ROSEMARY CHOI

5442 MCCULLOCH CIRLCE
HOUSTON, TX 77056

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
269			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

BROAD REACH BENEFITS INC

PO BOX 545
MADISON, NJ 07940

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
3360			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

JAY BERGMANN

232 SUNRISE COVE
AUSTIN, VT 78738

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
325			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

BRENNAN BAKER

6200 SAVOY
SUITE 345
HOUSTON, TX 77036

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
46			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

ALLEN COMMODORE BAKER

6200 SAVOY DR
SUITE 345
HOUSTON, TX 77036

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
159			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

ASSUREDPARTNERS OF HOUSTON LLC
6200 SAVOY DRIVE
SUITE 345
HOUSTON, TX 77036

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
4723			3

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(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	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a 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 connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	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			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [X] Other (specify) ▶ ACCIDENT, CRITICAL ILLNESS

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	82886
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ..... [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

00133
Metropolitan Life Insurance Company
501 U.S. Highway 22, 2nd Floor - West
Bridgewater, NJ 08807

MetLife

Sales & Broker Compensation Services

February 27, 2020

00133001004000000011

ATTENTION: BARBARA FULENWIDER
HFS HOLDING CORPORATION
8719 DIPLOMACY ROW
DALLAS, TX 75247

The Employee Retirement Income Security Act of 1974 ("ERISA") requires an annual financial report on employee welfare benefit plans and pension benefit plans which cover 100 or more participants at the beginning of the plan year and are subject to ERISA. The administrator of such a plan is required to file an annual report on I.R.S./DOL Form 5500, including the accompanying Schedule A, with the Employee Benefits Security Administration.

Your Metropolitan Life Insurance Company ("MetLife") employee welfare benefit plan may be subject to ERISA's annual reporting requirements and MetLife is therefore providing you with the information needed to complete Schedule A of Form 5500. The attached report is not an actual Schedule A form and should not be attached to the Form 5500 for regulatory filing. The information should be forwarded to the person who will be completing your annual filing. The information is taken from the data MetLife maintains within its normal business records and is, to the best of MetLife's knowledge and belief, complete and accurate.

Part I, Section 2 of this report lists the compensation paid to intermediaries related to your plan. Intermediaries may include brokers, consultants, agents and third-party administrators. There are several categories of compensation that may be paid to an intermediary. For your reference, the categories of compensation are listed below.

- Base Commissions - Base commissions are generally paid to an intermediary on a monthly basis and are usually calculated as a percentage of premium. Base commissions are typically factored into the cost of the customer's plan.
- Supplemental Compensation - Supplemental compensation may be paid to qualifying intermediaries based on an intermediary's new business or total inforce premium for a specified year. It is not MetLife's practice to specifically factor supplemental compensation into the cost of customer's plan. Supplemental compensation is factored into the price structure of MetLife's institutional business products.
- Fees - Fees may include payments made to intermediaries for services such as administration, communication, enrollment, billing, eligibility, recordkeeping, printing and mailing. Fees may be directly charged to the customer's plan.
- Award - If your intermediary received an award (such as travel or a gift) from MetLife, MetLife allocated the value of the award to all plans that were considered in the qualification criteria proportionately.

Note, the non-monetary compensation amount included in the Schedule A, Fees Paid section of the enclosed report is based on the calendar year tracking of all individual gifts or items of non-monetary compensation such as dinners, tickets for shows or other entertainment events, membership dues, hotels, equal to or greater than $10, that are given to or provided directly or indirectly to brokers, producers, and other insurance intermediaries and/or their spouses, companions or family members. This information is tracked and aggregated at the brokerage firm or company level. The total value is divided by the total number of active contracts or policies in place with that firm for that year except for items relating directly to a specific customer or customers (which are reported to the specific customer(s)). This allocation is reported on the Schedule A reports for all ERISA customers who are part of a given broker firm's book of business.

Before submitting the Schedule A with your annual report to the Employee Benefits Security Administration, in addition to the information MetLife has provided, you should enter in the Schedule the appropriate name of the plan, three-digit plan number and employer identification number in the appropriate spaces immediately preceding Part I.

You may also wish to consult with your counsel concerning any need for attaching an opinion by an independent qualified public accountant.

This letter, together with your copy of the complete annual report should be retained for at least the 6-year period required by ERISA.

* The Gross Dealer Concession is based on premiums received and represents the total compensation and fees paid by the Insurance Company to the selling firm for the coverage used to fund the plan. Your representative(s) received payments subject to selling agreements that they have with the selling firm. The remaining compensation is used by the distributor or selling firm to pay other expenses, including Management Compensation, Conference expenses, etc. The Gross Dealer Concession includes the Commission Paid which is listed separately. The Metropolitan Life Insurance Company attests that the foregoing statement is complete and accurate to the best of its knowledge, information, and belief.

If you have any questions please contact your MetLife Account Representative:
APRIL PHANDANOUVONG, +1 (813)673-3813 or 800-ASK-4-MET and MetLife will assist you in obtaining this information.

MetLife appreciates your business.

Official Use Only

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

▶ **File as an attachment to Form 5500**

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2019

This Form is Open to Public Inspection.

For calendar plan year 2019 or fiscal plan year beginning **01/01/2019** , and ending **12/31/2019**

A Name of plan	B Three digit plan number ▶	
C Plan sponsor's name as shown on line 2a of Form 5500 **HFS HOLDING CORPORATION**	D Employer Identification Number	

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 can be reported on a single Schedule A

1 Coverage:

(a) Name of insurance carrier

METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	**65978**	**5949232**	**205**	**01/01/2019**	**12/31/2019**

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part 1.

Totals *

Total amount of commissions paid	Total Fees Paid / amount
6,481	**0**

00133020040000000010

Part II

Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

Name: BROAD REACH BENEFITS INC

Address: 30 COOK PLZ STE 200 PO BOX 545 City: MADISON ST: NJ ZIP: 07940-1815

Commissions Paid			Fees Paid			Organization code
Coverage	**Amount**	**Purpose**	**Coverage**	**Amount**	**Purpose**	
Dental	6,481	Base Commissions				03
	6,481	**Sub-total**		0	**Sub-total**	

00133003004000000010

Official Use Only

00133004004000000016

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. 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.

8 Benefit and contract type (check all applicable boxes)

a		Health (other than dental or vision)	b	X	Dental	c		Vision	d		Life Insurance
e		Temporary disability (accident & sickness)	f		Long-term disability	g		Supplemental unemployment	h		Prescription drug
i		Stop Loss (large deductible)	j		HMO contract	k		PPO contract	l		Indemnity contract
m		Other (specify) ▶									

9 Experience-rated contracts **N/A**

10 Nonexperience-rated contracts

	Coverage	Amount
	Dental	65,130
a Total premiums or subscription charges paid to carrier		65,130
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount		

Specify nature of costs below ▶

Footnote(s)

Cancelled Policy 12/31/2019The approximate number of persons covered as shown on the first page of the Schedule A is MetLife's estimated view of participants, spouses and dependents at the end of the policy period. This estimation should be used for reporting purposes only.

If the plan named in Item A on the first page of Schedule A (the "Plan") retains the services of a broker, consultant, agent or third-party administrator (each an "Intermediary") for the Plan, MetLife may in addition to paying base commission provide additional compensation to the Intermediary under various preferred broker and other compensation programs and expense reimbursement. Under such programs, an Intermediary may qualify for additional compensation that may or may not be directly charged to the Plan. Such compensation may not be included in the amount listed in Item 2 on the first page of Schedule A. Please contact MetLife if you would like additional information or details.

Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175
mutualofomaha.com

May 19, 2020

HFS HOLDING CORP
8719 DIPLOMACY ROW
DALLAS, TX 75247

Re: Certified Information for Department of Labor
Form 5500, Schedule A – Group Number(s):

GLUG0BHHK	GMDC0BHHK	GUC 0BHHK
GUPR0BHHK	GVTL0BHHK	

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

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

HFS HOLDING CORP
DALLAS, TX

Name of Carrier:	United of Omaha Life Insurance Company - NAIC Code 69868		
EIN Number:	47-0322111		
Group Identification Number:	G000BHHK	**Data for Period:**	01-01-2019 to 01-01-2020
Legacy Group ID:	GLUG0BHHK		
Type of Contract:	NON-RETENTION		

Benefits Provided	Persons Covered
Life & AD&D	155

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums		12,803
Memo Items: Benefit Charges – Claims Paid	24,050	
Administrative Service Fees	0	

Group Office: NASHVILLE

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

HFS HOLDING CORP
DALLAS, TX

Name of Carrier:	Mutual of Omaha Insurance Company - NAIC Code 71412		
EIN Number:	47-0246511		
Group Identification Number:	G000BHHK	**Data for Period:**	01-01-2019 to 01-01-2020
Legacy Group ID:	GMDC0BHHK		
Type of Contract:	NON-RETENTION		

Benefits Provided	Persons Covered
AD&D Voluntary Stand Alone	54

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
BROAD REACH BENEFITS INC 30 COOK PLZ STE 200 PO BOX 545 MADISON, NJ 07940	362		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 3,625

Memo Items: Benefit Charges – Claims Paid 0
Administrative Service Fees 0

Group Office: NASHVILLE

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

HFS HOLDING CORP
DALLAS, TX

Name of Carrier:	United of Omaha Life Insurance Company - NAIC Code 69868		
EIN Number:	47-0322111		
Group Identification Number:	G000BHHK	**Data for Period:**	01-01-2019 to 01-01-2020
Legacy Group ID:	GUC 0BHHK		
Type of Contract:	NON-RETENTION		

Benefits Provided	Persons Covered
ShortTerm Disability Voluntary	94

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
BROAD REACH BENEFITS INC 30 COOK PLZ STE 200 PO BOX 545 MADISON, NJ 07940	2,071		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 23,007

Memo Items: Benefit Charges – Claims Paid 22,878
Administrative Service Fees 0

Group Office: NASHVILLE

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

HFS HOLDING CORP
DALLAS, TX

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000BHHK **Data for Period:** 01-01-2019 to 01-01-2020
Legacy Group ID: GUPR0BHHK
Type of Contract: NON-RETENTION

Benefits Provided	Persons Covered
Long Term Disability Voluntary	103

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
BROAD REACH BENEFITS INC 30 COOK PLZ STE 200 PO BOX 545 MADISON, NJ 07940	2,861		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 35,758

Memo Items: Benefit Charges – Claims Paid 11,887
Administrative Service Fees 0

Group Office: NASHVILLE

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

HFS HOLDING CORP
DALLAS, TX

Name of Carrier:	United of Omaha Life Insurance Company - NAIC Code 69868		
EIN Number:	47-0322111		
Group Identification Number:	G000BHHK	**Data for Period:**	01-01-2019 to 01-01-2020
Legacy Group ID:	GVTL0BHHK		
Type of Contract:	NON-RETENTION		

Benefits Provided	Persons Covered
Term Life - Voluntary	57

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
BROAD REACH BENEFITS INC 30 COOK PLZ STE 200 PO BOX 545 MADISON, NJ 07940	8,294		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 46,078

Memo Items: Benefit Charges – Claims Paid 0
Administrative Service Fees 0

Group Office: NASHVILLE

Swiss Re
Corporate Solutions

HFS Holding Corporation

5500 Report
Westport Insurance Corporation

5/19/2020

1/1/2019 - 12/31/2019

Policy Number	ESL 1000925 00	Tax Id	48-0921045
Commission Rate	15%	NAIC	39845

Month	Stop Loss Premium	Census
January	31,954.00	121
February	33,167.00	126
March	31,954.00	121
April	35,998.00	135
May	27,909.00	107
June	31,954.00	121
July	33,167.00	124
August	31,145.00	122
September	31,752.00	121
October	35,391.00	130
November	32,763.00	124
December	31,752.00	121
Total	388,906.00	1,473

Swiss Re
Corporate Solutions

HFS Holding Corporation -OTS

5500 Report
Westport Insurance Corporation

5/19/2020

1/1/2019 - 12/31/2019

Policy Number	ESL 1100256 00	Tax Id	48-0921045
Commission Rate	10%	NAIC	39845

Month	Stop Loss Premium	Census
January	1,678.00	126
February	1,618.00	121
March	1,618.00	121
April	1,618.00	121
May	1,618.00	121
June	1,618.00	121
July	1,687.00	124
August	1,559.00	122
September	1,605.00	121
October	1,811.00	130
November	1,660.00	124
December	1,605.00	121
Total	19,695.00	1,473

HFS HOLDING CORPORATION(27226)
8719 DIPLOMACY ROW
DALLAS TX 75247



Plan/Contract Year:1/1/2019-12/31/2019
Part I (a) Name of Insurance Carrier: American Heritage Life Insurance Company
Part I (b) EIN: 59-0781901
Part I (c) NAIC Code: 60534

Includes the Following Accounts: 27226

Part I, Sec 1 (d) Contract or Identification Number	Part I, Sec 1 (e) Number of Persons Covered at end of Contract Year	Part III, Sec 10a Total Premium or Subscription Charges to carrier	Part I, Sec 3 Name and Address of the Agents	Agent Number	Part I, Sec 2 Total Commissions Paid	Part I, Sec 2 (c) Total amount of Fees paid	Part I, Sec 3 (d) Purpose of Fee
Accident Account: 27226							
Accident	**68**	**$27,010.40**			**$3,723.07**	**$0.00**	
			ASSUREDPARTNERS OF HOUSTON LLC DBA PROF ENROLLMENT CONCEPTS 6200 SAVOY DRIVE STE 345 HOUSTON TX 77036	7RHW0	$1,674.93	$0.00	
			BAKER ALLEN COMMODORE 6200 SAVOY DR SUITE 345 HOUSTON TX 77036	9KLY0	$66.22	$0.00	
			BAKER BRENNAN 6200 SAVOY SUITE 345 HOUSTON TX 77036	800L0	$19.04	$0.00	
			BERGMANN JAY 232 SUNRISE RIDGE COVE AUSTIN TX 78738	4F0R0	$141.99	$0.00	
			BROAD REACH BENEFITS INC P O BOX 545 MADISON NJ 07940	781N0	$718.61	$0.00	
			CHOI ROSEMARY 5442 MCCULLOCH CIRCLE HOUSTON TX 77056	8CMX0	$110.12	$0.00	

Disclaimers:

- Number of Persons covered represents the total certificates in force on the Plan Year end date.
- Total premium represent premium that is both received and applied during the Plan Year; this is referred to as 'Paid Premium'.
- Total Commissions Paid and Total Fees Paid reflect the respective amounts paid during the Plan Year.

	GARCIA MARIA 7215 BOYCE ST HOUSTON TX 77020	2M0L0	$9.22	$0.00	
	INGLIS BRYAN 104 PENNS WAY SHAVANO PARK TX 78231	8XGC0	$59.02	$0.00	
	MORENO DALLAS 6200 SAVOY DR SUITE 345 HOUSTON TX 77036	9PEF0	$3.59	$0.00	
	PENKO BRANDON 4927 MAGNOLIA BEND DR ROSHARON TX 77583	8EFB0	$84.54	$0.00	
	USI SOUTHWEST INC PO BOX 61187 VIRGINIA BEACH VA 23466	8XFA0	$823.82	$0.00	
	VANESSA AYALA 1790 RUSSELL LANE SAN BENITO TX 78586	3P0L0	$11.53	$0.00	
	WISE ALLISON A 7142 LAGUNA VILLAS HOUSTON TX 77036	8GTK0	$0.44	$0.00	

Disclaimers:

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- Total Commissions Paid and Total Fees Paid reflect the respective amounts paid during the Plan Year.

HFS HOLDING CORPORATION(27226)
8719 DIPLOMACY ROW
DALLAS TX 75247



Plan/Contract Year:1/1/2019-12/31/2019
Part I (a) Name of Insurance Carrier: American Heritage Life Insurance Company
Part I (b) EIN: 59-0781901
Part I (c) NAIC Code: 60534

Includes the Following Accounts: 27226

Part I, Sec 1 (d) Contract or Identification Number	Part I, Sec 1 (e) Number of Persons Covered at end of Contract Year	Part III, Sec 10a Total Premium or Subscription Charges to carrier	Part I, Sec 3 Name and Address of the Agents	Agent Number	Part I, Sec 2 Total Commissions Paid	Part I, Sec 2 (c) Total amount of Fees paid	Part I, Sec 3 (d) Purpose of Fee
Critical Illness Account: 27226							
Critical Illness	**47**	**$26,125.95**			**$5,038.33**	**$0.00**	
			ASSUREDPARTNERS OF HOUSTON LLC DBA PROF ENROLLMENT CONCEPTS 6200 SAVOY DRIVE STE 345 HOUSTON TX 77036	7RHW0	$1,867.18	$0.00	
			BAKER ALLEN COMMODORE 6200 SAVOY DR SUITE 345 HOUSTON TX 77036	9KLY0	$61.90	$0.00	
			BAKER BRENNAN 6200 SAVOY SUITE 345 HOUSTON TX 77036	800L0	$14.91	$0.00	
			BERGMANN JAY 232 SUNRISE RIDGE COVE AUSTIN TX 78738	4F0R0	$141.00	$0.00	
			BROAD REACH BENEFITS INC P O BOX 545 MADISON NJ 07940	781N0	$1,782.19	$0.00	
			CHOI ROSEMARY 5442 MCCULLOCH CIRCLE HOUSTON TX 77056	8CMX0	$107.16	$0.00	

Disclaimers:

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- Total premium represent premium that is both received and applied during the Plan Year; this is referred to as 'Paid Premium'.
- Total Commissions Paid and Total Fees Paid reflect the respective amounts paid during the Plan Year.

	GARCIA MARIA 7215 BOYCE ST HOUSTON TX 77020	2M0L0	$14.39	$0.00	
	INGLIS BRYAN 104 PENNS WAY SHAVANO PARK TX 78231	8XGC0	$51.93	$0.00	
	MORENO DALLAS 6200 SAVOY DR SUITE 345 HOUSTON TX 77036	9PEF0	$7.85	$0.00	
	PENKO BRANDON 4927 MAGNOLIA BEND DR ROSHARON TX 77583	8EFB0	$86.38	$0.00	
	USI SOUTHWEST INC PO BOX 61187 VIRGINIA BEACH VA 23466	8XFA0	$894.84	$0.00	
	VANESSA AYALA 1790 RUSSELL LANE SAN BENITO TX 78586	3P0L0	$8.10	$0.00	
	WISE ALLISON A 7142 LAGUNA VILLAS HOUSTON TX 77036	8GTK0	$0.50	$0.00	

Disclaimers:

- Number of Persons covered represents the total certificates in force on the Plan Year end date.
- Total premium represent premium that is both received and applied during the Plan Year; this is referred to as 'Paid Premium'.
- Total Commissions Paid and Total Fees Paid reflect the respective amounts paid during the Plan Year.

HFS HOLDING CORPORATION(27226)
8719 DIPLOMACY ROW
DALLAS TX 75247



Plan/Contract Year:1/1/2019-12/31/2019
Part I (a) Name of Insurance Carrier: American Heritage Life Insurance Company
Part I (b) EIN: 59-0781901
Part I (c) NAIC Code: 60534

Includes the Following Accounts: 27226

Part I, Sec 1 (d) Contract or Identification Number	Part I, Sec 1 (e) Number of Persons Covered at end of Contract Year	Part III, Sec 10a Total Premium or Subscription Charges to carrier	Part I, Sec 3 Name and Address of the Agents	Agent Number	Part I, Sec 2 Total Commissions Paid	Part I, Sec 2 (c) Total amount of Fees paid	Part I, Sec 3 (d) Purpose of Fee
Universal Life Account: 27226							
Universal Life	**53**	**$29,749.80**			**$2,767.50**	**$0.00**	
			ASSUREDPARTNERS OF HOUSTON LLC DBA PROF ENROLLMENT CONCEPTS 6200 SAVOY DRIVE STE 345 HOUSTON TX 77036	7RHW0	$1,181.03	$0.00	
			BAKER ALLEN COMMODORE 6200 SAVOY DR SUITE 345 HOUSTON TX 77036	9KLY0	$31.35	$0.00	
			BAKER BRENNAN 6200 SAVOY SUITE 345 HOUSTON TX 77036	800L0	$12.15	$0.00	
			BERGMANN JAY 232 SUNRISE RIDGE COVE AUSTIN TX 78738	4F0R0	$41.64	$0.00	
			BROAD REACH BENEFITS INC P O BOX 545 MADISON NJ 07940	781N0	$859.40	$0.00	
			CHOI ROSEMARY 5442 MCCULLOCH CIRCLE HOUSTON TX 77056	8CMX0	$52.17	$0.00	

Disclaimers:

- Number of Persons covered represents the total certificates in force on the Plan Year end date.
- Total premium represent premium that is both received and applied during the Plan Year; this is referred to as 'Paid Premium'.
- Total Commissions Paid and Total Fees Paid reflect the respective amounts paid during the Plan Year.

		GARCIA MARIA 7215 BOYCE ST HOUSTON TX 77020	2M0L0	$4.61	$0.00	
		INGLIS BRYAN 104 PENNS WAY SHAVANO PARK TX 78231	8XGC0	$38.60	$0.00	
		MORENO DALLAS 6200 SAVOY DR SUITE 345 HOUSTON TX 77036	9PEF0	$3.75	$0.00	
		PENKO BRANDON 4927 MAGNOLIA BEND DR ROSHARON TX 77583	8EFB0	$27.95	$0.00	
		USI SOUTHWEST INC PO BOX 61187 VIRGINIA BEACH VA 23466	8XFA0	$503.43	$0.00	
		VANESSA AYALA 1790 RUSSELL LANE SAN BENITO TX 78586	3P0L0	$11.11	$0.00	
		WISE ALLISON A 7142 LAGUNA VILLAS HOUSTON TX 77036	8GTK0	$0.31	$0.00	
Grand Total	**$82,886.15**			**$11,528.90**	**$0.00**	

Disclaimers:

- Number of Persons covered represents the total certificates in force on the Plan Year end date.
- Total premium represent premium that is both received and applied during the Plan Year; this is referred to as 'Paid Premium'.
- Total Commissions Paid and Total Fees Paid reflect the respective amounts paid during the Plan Year.