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

2020

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

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
FLEXIBLE SPENDING PLAN

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 01/01/1993

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)
KEATS MANUFACTURING CO.

350 HOLBROOK DR
WHEELING, IL 60090-5812

350 HOLBROOK DR
WHEELING, IL 60090-5812

2b Employer Identification Number (EIN) 36-2388828

2c Plan Sponsor's telephone number 847-226-4433

2d Business code (see instructions) 332900

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.	06/25/2021	RONALD MCCONVILLE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	06/25/2021	RONALD MCCONVILLE
	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**	177
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)**	177
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	165
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**	165
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	165
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 4E

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] 3 **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 2020 Form M-1 annual report. If the plan was not required to file the 2020 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

2020

This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

A Name of plan
FLEXIBLE SPENDING PLAN

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
KEATS MANUFACTURING CO.

D Employer Identification Number (EIN)
36-2388828

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
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(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
13-5123390	64246	00540664	121	01/01/2020	12/31/2020

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
4888	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

FIRST BENEFITS CORPORATION
155 N WACKER DRIVE
42ND FLOOR
CHICAGO, IL 60606

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
4888	0		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** [X] 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**	21390
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

2020

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For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

A Name of plan
FLEXIBLE SPENDING PLAN

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
KEATS MANUFACTURING CO.

D Employer Identification Number (EIN)
36-2388828

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
BLUE CROSS BLUE SHIELD OF ILLINOIS

(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
36-1236610	70670	223175	218	01/01/2020	12/31/2020

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
50937	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

TRUE NORTH COMPANIES, L.C.
PO BOX 1863
CEDAR RAPIDS, IA 52406

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
50052	885		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** [X] 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**	1293419
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

2020

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For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

A Name of plan
FLEXIBLE SPENDING PLAN

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
KEATS MANUFACTURING CO.

D Employer Identification Number (EIN)
36-2388828

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 CO.

(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	5930100	165	01/01/2020	12/31/2020

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
5255	1323

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

TRUE NORTH COMPANIES, L.C.
PO BOX 1863
CEDAR RAPIDS, IA 52406

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
5255	1323		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	

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	(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) ▶ ADD

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**	43283
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. ▶

00080
Metropolitan Life Insurance Company
501 U.S. Highway 22, 2nd Floor - West
Bridgewater, NJ 08807

MetLife

Sales & Broker Compensation Services

October 26, 2020

0008000100400000000011

ATTENTION: MATT EGGEMEYER
KEATS MANUFACTURING
350 HOLBROOK DRIVE
WHEELING, IL 60090

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:
ALLISON BAKER, +1 (813)673-3783 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 **09/01/2019** , and ending **08/31/2020**

A Name of plan	**B** Three digit plan number ▶
C Plan sponsor's name as shown on line 2a of Form 5500 **KEATS MANUFACTURING**	**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**	**5930100**	**165**	**09/01/2019**	**08/31/2020**

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
5,255	**1,323**

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Part II

Official Use Only

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

Name: TRUENORTH COMPANIES L C

Address: PO BOX 1863 City: CEDAR RAPIDS ST: IA ZIP: 52406-1863

Commissions Paid			Fees Paid			Organization code
Coverage	**Amount**	**Purpose**	**Coverage**	**Amount**	**Purpose**	
Long Term Disability	2,368	Base Commissions	Temporary Disability	480	Supplemental Compensation	03
Temporary Disability	1,448	Base Commissions	Long Term Disability	430	Supplemental Compensation	
LIFE	1,325	Base Commissions	LIFE	378	Supplemental Compensation	
AD&D	114	Base Commissions	AD&D	35	Supplemental Compensation	
	5,255	**Sub-total**		1,323	**Sub-total**	

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Official Use Only

00080004004000000010

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		Dental	c		Vision	d	X	Life Insurance
e	X	Temporary disability (accident & 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) ▶ ADD									

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

10 Nonexperience-rated contracts

Coverage	Amount
Long Term Disability	15,927
Temporary Disability	13,614
LIFE	12,607
AD&D	1,135

a	Total premiums or subscription charges paid to carrier	43,283
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)

The 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.

Incoming: Sharon_Williams@glic.com Sender: M&B_Imaging_Backend@glic.com

From: Sharon Williams
Sent: 12 Aug 2020 20:08:15 +0000
To: M&B Imaging Backend
Subject: 540664 - 5500
Attachments: 5500 Letter by Plan (3).pdf

---------- This message, and any attachments to it, may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, you are notified that any use, dissemination, distribution, copying, or communication of this message is strictly prohibited. If you have received this message in error, please notify the sender immediately by return e-mail and delete the message and any attachments. Thank you.

MB20200812801018200l 8/12/2020 4:09:22 PM Page 1 of 10

Guardian

EUNICE MCCONVILLE
KEATS MANUFACTURING CO.
350 HOLBROOK DR
WHEELING, IL 60090

August 12, 2020

Plan Number : 00540664
Anniversary Date : 7/1/20

To help you with the preparation of your form 5500 (Annual Return / Report of Employee Benefit Plan ERISA) for filing with the Department of Labor, we are providing the following information.

You are required to transfer the information from this form to the appropriate schedule, forming Part of the 5500 form furnished by the United States Department of Labor. You will also need Guardian's Tax ID (EIN) and NAIC numbers, which are as follows :

EIC : 13-5123390

NAIC: 64246

A copy of this form should be retained for your records.

Certified to be correct

The Guardian Life Insurance Company of America.



1-800-627-4200

Guardian

Name of Plan : **KEATS MANUFACTURING CO.**

Plan Number : **00540664**

Data for Period From : **7/1/19** To : **6/30/20**

The approximate number of employees covered at the end of the plan year : 121

Group Insurance coverage(s) included under this Plan :

Dental (Alternately funded), Vision (Insured)

The following figure represents commissions that are to be reported on Schedule A, Line 2, Element (b):

Contract Identification	Name and Address of Recipient of Commissions	Amount
000H6750	FIRST BENEFITS CORPORATION 155 N WACKER DR 42 FLOOR CHICAGO IL 60606	$4,887.93
	Total Commission Paid	**$4,887.93**

The following figure represents fees that are to be reported on Schedule A, Line 2, Element (c):

Contract Identification	Name of Recipient of Fees	Amount
	Total Fees Paid	

However, the compensation listed above is not charged to your case in calculating new rates.

Premium due and unpaid at the end of plan year	:	**$0.00**
List gross premium for each contract	:	**$21,389.34**

Name of Plan: *KEATS MANUFACTURING CO.*

Plan Number: 00540664

The following figure represents Indirect Compensation to be reported on Schedule C, Part 1, 3, Elements (a & c)

Contract Identification (a)	Name and Address of Recipient of Indirect Compensation (a)	Amount (c)
	Total Indirect Compensation Paid:	

The following is for Indirect Compensation information to be reported on Schedule C, Part 1, 3, Elements (b, d & e)

Service Code (b)	Name and Address (d)	Indirect Compensation (e)

Guardian

Agency	Agent	Plan Number	Division Number	Cluster	BT	BN	Comm Type	Bill Due Date	Create Dt	Commission Amount
000H6	750	00540664	0	T	AT	T0101A	Z	7/1/2019	7/26/2019	$310.34
000H6	750	00540664	0	V	VI	G0049A	Z	7/1/2019	7/26/2019	$25.85
000H6	750	00540664	0	V	VI	G0066A	Z	7/1/2019	7/26/2019	$64.30
000H6	750	00540664	0	T	AT	T0101A	Z	8/1/2019	8/30/2019	$337.55
000H6	750	00540664	0	V	VI	G0049A	Z	8/1/2019	8/30/2019	$36.35
000H6	750	00540664	0	V	VI	G0066A	Z	8/1/2019	8/30/2019	$63.55
000H6	750	00540664	0	T	AT	T0101A	Z	9/1/2019	9/27/2019	$313.06
000H6	750	00540664	0	V	VI	G0049A	Z	9/1/2019	9/27/2019	$31.10
000H6	750	00540664	0	V	VI	G0066A	Z	9/1/2019	9/27/2019	$54.55
000H6	750	00540664	0	T	AT	T0101A	Z	10/1/2019	10/25/2019	$313.06
000H6	750	00540664	0	V	VI	G0049A	Z	10/1/2019	10/25/2019	$31.10
000H6	750	00540664	0	V	VI	G0066A	Z	10/1/2019	10/25/2019	$59.80
000H6	750	00540664	0	T	AT	T0101A	Z	11/1/2019	11/22/2019	$307.61
000H6	750	00540664	0	V	VI	G0049A	Z	11/1/2019	11/22/2019	$31.10
000H6	750	00540664	0	V	VI	G0066A	Z	11/1/2019	11/22/2019	$56.80
000H6	750	00540664	0	T	AT	T0101A	Z	12/1/2019	12/20/2019	$315.78
000H6	750	00540664	0	V	VI	G0049A	Z	12/1/2019	12/20/2019	$31.10
000H6	750	00540664	0	V	VI	G0066A	Z	12/1/2019	12/20/2019	$58.30
000H6	750	00540664	0	T	AT	T0101A	Z	1/1/2020	1/24/2020	$310.34
000H6	750	00540664	0	V	VI	G0049A	Z	1/1/2020	1/24/2020	$31.10
000H6	750	00540664	0	V	VI	G0066A	Z	1/1/2020	1/24/2020	$58.30
000H6	750	00540664	0	T	AT	T0101A	Z	2/1/2020	2/21/2020	$313.76
000H6	750	00540664	0	V	VI	G0049A	Z	2/1/2020	2/21/2020	$31.10
000H6	750	00540664	0	V	VI	G0066A	Z	2/1/2020	2/21/2020	$58.40

Guardian

Agency	Agent	Plan Number	Division Number	Cluster	BT	BN	Comm Type	Bill Due Date	Create Dt	Commission Amount
000H6	750	00540664	0	T	AT	T0101A	Z	3/1/2020	3/27/2020	$321.22
000H6	750	00540664	0	V	VI	G0049A	Z	3/1/2020	3/27/2020	$31.10
000H6	750	00540664	0	V	VI	G0066A	Z	3/1/2020	3/27/2020	$62.95
000H6	750	00540664	0	T	AT	T0101A	Z	4/1/2020	4/24/2020	$318.50
000H6	750	00540664	0	V	VI	G0049A	Z	4/1/2020	4/24/2020	$31.10
000H6	750	00540664	0	V	VI	G0066A	Z	4/1/2020	4/24/2020	$60.65
000H6	750	00540664	0	T	AT	T0101A	Z	5/1/2020	5/22/2020	$318.51
000H6	750	00540664	0	V	VI	G0049A	Z	5/1/2020	5/22/2020	$31.10
000H6	750	00540664	0	V	VI	G0066A	Z	5/1/2020	5/22/2020	$60.65
000H6	750	00540664	0	T	AT	T0101A	Z	6/1/2020	6/26/2020	$318.50
000H6	750	00540664	0	V	VI	G0049A	Z	6/1/2020	6/26/2020	$30.30
000H6	750	00540664	0	V	VI	G0066A	Z	6/1/2020	6/26/2020	$59.05
									Total	**$4,887.93**

Guardian

Plan Number	Division Number	BT	BN	Bill Due Date	Create Date	Due Premium Amount
00540664	0	AT	T0101A	7/1/2019	6/27/2019	$857.28
00540664	0	AT	T0101A	8/1/2019	7/18/2019	$932.48
00540664	0	AT	T0101A	9/1/2019	8/16/2019	$864.80
00540664	0	AT	T0101A	10/1/2019	9/13/2019	$864.80
00540664	0	AT	T0101A	11/1/2019	10/16/2019	$849.76
00540664	0	AT	T0101A	12/1/2019	11/14/2019	$872.32
00540664	0	AT	T0101A	1/1/2020	12/13/2019	$857.28
00540664	0	AT	T0101A	2/1/2020	1/17/2020	$866.74
00540664	0	AT	T0101A	3/1/2020	2/14/2020	$887.36
00540664	0	AT	T0101A	4/1/2020	3/18/2020	$879.84
00540664	0	AT	T0101A	5/1/2020	4/16/2020	$879.84
00540664	0	AT	T0101A	6/1/2020	5/15/2020	$879.84
00540664	0	VI	G0049A	7/1/2019	6/27/2019	$258.50
00540664	0	VI	G0049A	8/1/2019	7/18/2019	$363.50
00540664	0	VI	G0049A	9/1/2019	8/16/2019	$311.00
00540664	0	VI	G0049A	10/1/2019	9/13/2019	$311.00
00540664	0	VI	G0049A	11/1/2019	10/16/2019	$311.00
00540664	0	VI	G0049A	12/1/2019	11/14/2019	$311.00
00540664	0	VI	G0049A	1/1/2020	12/13/2019	$311.00
00540664	0	VI	G0049A	2/1/2020	1/17/2020	$311.00
00540664	0	VI	G0049A	3/1/2020	2/14/2020	$311.00
00540664	0	VI	G0049A	4/1/2020	3/18/2020	$311.00
00540664	0	VI	G0049A	5/1/2020	4/16/2020	$311.00
00540664	0	VI	G0049A	6/1/2020	5/15/2020	$303.00
00540664	0	VI	G0066A	7/1/2019	6/27/2019	$643.00
00540664	0	VI	G0066A	8/1/2019	7/18/2019	$635.50
00540664	0	VI	G0066A	9/1/2019	8/16/2019	$545.50
00540664	0	VI	G0066A	10/1/2019	9/13/2019	$598.00

Guardian

Plan Number	Division Number	BT	BN	Bill Due Date	Create Date	Due Premium Amount
00540664	0	VI	G0066A	11/1/2019	10/16/2019	$568.00
00540664	0	VI	G0066A	12/1/2019	11/14/2019	$583.00
00540664	0	VI	G0066A	1/1/2020	12/13/2019	$583.00
00540664	0	VI	G0066A	2/1/2020	1/17/2020	$584.00
00540664	0	VI	G0066A	3/1/2020	2/14/2020	$629.50
00540664	0	VI	G0066A	4/1/2020	3/18/2020	$606.50
00540664	0	VI	G0066A	5/1/2020	4/16/2020	$606.50
00540664	0	VI	G0066A	6/1/2020	5/15/2020	$590.50
					Total	**$21,389.34**

Guardian

Plan Number	Division Number	BT	BN	Bill Due Date	Create Date	Paid Premium Amount
00540664	0	AT	T0101A	7/1/2019	7/22/2019	$857.28
00540664	0	AT	T0101A	8/1/2019	8/26/2019	$932.48
00540664	0	AT	T0101A	9/1/2019	9/24/2019	$864.80
00540664	0	AT	T0101A	10/1/2019	10/22/2019	$864.80
00540664	0	AT	T0101A	11/1/2019	11/19/2019	$849.76
00540664	0	AT	T0101A	12/1/2019	12/18/2019	$872.32
00540664	0	AT	T0101A	1/1/2020	1/22/2020	$857.28
00540664	0	AT	T0101A	2/1/2020	2/19/2020	$866.74
00540664	0	AT	T0101A	3/1/2020	3/24/2020	$887.36
00540664	0	AT	T0101A	4/1/2020	4/20/2020	$879.84
00540664	0	AT	T0101A	5/1/2020	5/19/2020	$879.84
00540664	0	AT	T0101A	6/1/2020	6/23/2020	$879.84
00540664	0	VI	G0049A	7/1/2019	7/22/2019	$258.50
00540664	0	VI	G0049A	8/1/2019	8/26/2019	$363.50
00540664	0	VI	G0049A	9/1/2019	9/24/2019	$311.00
00540664	0	VI	G0049A	10/1/2019	10/22/2019	$311.00
00540664	0	VI	G0049A	11/1/2019	11/19/2019	$311.00
00540664	0	VI	G0049A	12/1/2019	12/18/2019	$311.00
00540664	0	VI	G0049A	1/1/2020	1/22/2020	$311.00
00540664	0	VI	G0049A	2/1/2020	2/19/2020	$311.00
00540664	0	VI	G0049A	3/1/2020	3/24/2020	$311.00
00540664	0	VI	G0049A	4/1/2020	4/20/2020	$311.00
00540664	0	VI	G0049A	5/1/2020	5/19/2020	$311.00
00540664	0	VI	G0049A	6/1/2020	6/23/2020	$303.00
00540664	0	VI	G0066A	7/1/2019	7/22/2019	$643.00
00540664	0	VI	G0066A	8/1/2019	8/26/2019	$635.50
00540664	0	VI	G0066A	9/1/2019	9/24/2019	$545.50
00540664	0	VI	G0066A	10/1/2019	10/22/2019	$598.00

Guardian

Plan Number	Division Number	BT	BN	Bill Due Date	Create Date	Paid Premium Amount
00540664	0	VI	G0066A	11/1/2019	11/19/2019	$568.00
00540664	0	VI	G0066A	12/1/2019	12/18/2019	$583.00
00540664	0	VI	G0066A	1/1/2020	1/22/2020	$583.00
00540664	0	VI	G0066A	2/1/2020	2/19/2020	$584.00
00540664	0	VI	G0066A	3/1/2020	3/24/2020	$629.50
00540664	0	VI	G0066A	4/1/2020	4/20/2020	$606.50
00540664	0	VI	G0066A	5/1/2020	5/19/2020	$606.50
00540664	0	VI	G0066A	6/1/2020	6/23/2020	$590.50
					Total	**$21,389.34**

BlueCross BlueShield of Illinois

April 19, 2021

Attn: MATT EGGEMEYER
Keats Manufacturing
350 WEST HOLBROOK DRIVE
WHEELING, IL 60090-5812

RE: Information You need To Complete Form 5500
Policy Period: 01/01/2020 Through 12/31/2020
Group Number(s) and/or Control Number: 253132 B23175 PI0541 PI0542 PI0543

Note: This Information is being forwarded to the main account contact name in our records. You may find it appropriate to pass this information along to the person or department responsible for completing your company's tax information.

In accordance with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), attached is the information you need to complete the Form 5500 for the plan year and group numbers referenced above. Our newly updated procedures and processes now require us to provide this information to you automatically. Therefore, even though you may not have requested the information in the past, you are now receiving it for your records.

If you have seen this type of information in the past, you may note some changes as a result of our upated procedures. In particular, the section near the bottom of the exhibit now includes more detailed broker commission information, if applicable. The additional details are provided as the result of a recent Advisory Opinion issued by the Department of Labor regarding what information is to be reported on Form 5500 regarding compensation and fees paid to brokers, agents and others. The footnotes on the exhibit itself will provide further information for your reference.

If you have any questions, please contact your BlueCross BlueShield Account Representative.

FORM 5500 INFORMATION

Name of Plan:
Keats Manufacturing

Group Number(s):
253132 B23175 PI0541 PI0542 PI0543

From: 01/01/2020 Through: 12/31/2020

1. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY OR CONTRACT PERIOD:	**218**	
2. EXPERIENCE RATED CONTRACTS		
Premiums:		
Amount Billed	$0.00	
Amount Due but Unpaid	$0.00	
Total Premiums Earned		$0.00
Benefit Charges:		
Net Claims Incurred*	$0.00	
Change in Claim Reserves	$0.00	
Change in other Reserves	$0.00	
Total Claims Incurred		$0.00
Retention Charges:		
Commissions	$0.00	
Service Fees	$0.00	
Administrative Expenses	$0.00	
Deficit Change	$0.00	
Access Fees	$0.00	
Other (Interest Credit)	$0.00	
Total Retention		$0.00
Experience or Retroactive Rate Refunds		$0.00
Status of Policyholder Reserves at End of Year:		
Amount Held for Benefits After Retirement		$0.00
Claim Reserves		$0.00
Other Reserves		$0.00
3. NON EXPERIENCE RATED CONTRACTS		
Total Premiums Earned		$1,293,418.84

4. COMMISSIONS AND CONSULTANT SERVICE FEES

	Name of Recipient:	Amount Paid:
a. Base Commissions **	TRUENORTH COMPANIES, L.C.	$50,051.34
b. Other Commissions ***		
c. Special Programs ****	TRUENORTH COMPANIES, L.C.	$885.00

STATEMENT PREPARED BY HEALTH CARE SERVICE CORPORATION 04/19/2021

* Based on the rates, terms and conditions specified in the Agreement between the Plan and HCSC.

NOTE: The above information is provided from business records of BCBSIL maintained in the ordinary course of BCBSIL's business to assist the plan administrator in complying with certain plan reporting requirements for Form(s) 5500. BCBSIL certifies that this information is accurate and complete to the best of its knowledge and belief.
** - Base commissions paid on your contract or policy.
*** - Other commissions paid on your contract or policy such as General Agent commissions.
**** - Special programs and/or bonuses that are paid based on a broker/consultant's total volume. To calculate the proportion of the bonus allocated to your contract or policy, your eligible volume is divided by the broker/consultant's total volume. That fraction is multiplied by the total bonus to get the allocated portion.

The amounts shown in section 4b and 4c do not directly impact your overall premium and administrative fees.

FEIN (Federal Employer Identification Number): 36 - 1236610
NAIC Company Code: 70670