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 10/01/2019 and ending 09/30/2020

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.)
- [X] 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:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
CENTRAL FLORIDA MOTOR SALES, INC. FLEXIBLE BENEFITS PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 10/01/1996

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)
CENTRAL FLORIDA MOTOR SALES, INC.
D/B/A TOYOTA OF ORLANDO

3575 VINELAND ROAD
ORLANDO, FL 32811-6435

2b Employer Identification Number (EIN) 27-3500528

2c Plan Sponsor's telephone number 407-298-4500

2d Business code (see instructions) 441110

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.	07/12/2021	R. TODD BOBO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/12/2021	R. TODD BOBO
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Filed with authorized/valid electronic signature.		
	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**	693
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)**	693
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	703
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**	703
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
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 4E 4F 4H 4Q

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] 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)** [ ] 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)** [X] **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 10/01/2019 and ending 09/30/2020

A Name of plan
CENTRAL FLORIDA MOTOR SALES, INC. FLEXIBLE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
CENTRAL FLORIDA MOTOR SALES, INC.

D Employer Identification Number (EIN)
27-3500528

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
COLONIAL LIFE & ACCIDENT 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
57-0144607	62049	E3986247	112	08/01/2019	07/31/2020

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
19098	2679

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

INSURANCE OFFICE OF AMERICA
1855 W STATE ROAD #434
LONGWOOD, FL 32750

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
8714			3

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

WORKSITE BENEFITS SOLUTION, LLC
1009 VERONA ST.
KISSIMMEE, FL 34741

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
2419	1231	BROKER BONUS	3

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

ERIKA ROBERTS-POE
2146 STONE PILE DR. SW.
CONCORD, NC 27025

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1675	256	BROKER BONUS	3

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

SARAH WEYMOUTH
306 MAPLE AVE
KISSIMMEE, FL 34741

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1449	432	BROKER BONUS	3

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

JUAN CARLOS SUAREZ
5415 BRIDEGEGATE
WINSTON SALEM, NC 27106

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
756	13	BROKER BONUS	3

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

LISA LOWE CLARKE
4604 KILLIAN CROSSING DRIVE
DENVER, NC 28037

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
721	10	BROKER BONUS	3

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

CALVON Y. BUCZKOWSKI
2608 TALL MAPLE LOOP
OCOEE, FL 34761

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
462	197	BROKER BONUS	3

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

JENNIFER WEYMOUTH RESMONDO
2940 OAKTREE DR
KISSIMMEE, FL 34744

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
491	119	BROKER BONUS	3

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

CEDORA B. LEVINER
P.O. BOX 758
KANNAPOLIS, NC 28082

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
487	20	BROKER BONUS	3

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

OMAR ENRIQUE FIGUEROA
3424 DOUGLAS CT.
KISSIMMEE, FL 34746

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
396	50	BROKER BONUS	3

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

DAVID MASON DOKELL
159 BEACON DRIVE
MOORESVILLE, NC 28117

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
153	90	BROKER BONUS	3

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

JOHN L. MORRIS
117 ALLISON STREET
FORT MILL, SC 29715

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
217	7	BROKER BONUS	3

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

JEAN A. MARCHI

P.O. BOX 1677
MT. AIRY, NC 27030

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
112	93	BROKER BONUS	3

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

TONI E. STEED, LLC

11218 WARFIELD AVE
HUNTERSVILLE, NC 28078

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
161			3

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

THE CLARK GROUP OF SC

589 WINDMERE DR
LEXINGTON, SC 29072

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
54	62	BROKER BONUS	3

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

MICHAEL N. THORN

3 MAINSAIL COURT
GREENSBORO, NC 27455

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
85	13	BROKER BONUS	3

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

ARTHUR WAYNE JORDAN JR.

514 OAKWOOD AVE.
RALEIGH, NC 27601

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
92			3

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

ADVANCED BENEFIT SYSTEM, INC.
145 RIVER LANDING DRIVE
DANIEL ISLAND, SC 29492

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
37	40	BROKER BONUS	3

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

BENEFITS COUNT II, INC
1401 CHRISTIMAS COURT
RALEIGH, NC 27604

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
48	27	BROKER BONUS	3

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

DAVID UNDERWOOD
P.O. BOX 32694
CHARLOTTE, NC 28232

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
69			3

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

DONNA N. DWYER
1540 WESTBROOK PLAZA DR.
WINSTON SALEM, NC 27103

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
60	9	BROKER BONUS	3

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

BRYCE WILLIAM SMITH
4212 AUDUBON PARK DR
CHARLOTTE, NC 28217

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
54	4	BROKER BONUS	3

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

GINAKES & ASSOCIATES, LLC
1020 WEST INTERNATIONAL SPEEDWAY
DAYTONA BEACH, FL 32114

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
57			3

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

KJELL T. TERRELL
327 GOLF COURSE DR
RALEIGH, NC 27610

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
55			3

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

KRISTEN BIBLE
5461 TRALEE PLACE
RALEIGH, NC 27609

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
49	3	BROKER BONUS	3

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

JESSIE R. CAPLEY
1716 STILLWATER DR
COLUMBIA, SC 29212

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
51			3

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

Z3 ENTERPRISES INC
1510 HIGH ROCK ROAD
GIBSONVILLE, NC 27249

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
41			3

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

LYNN C. GARRETT
900 CAROLINA AVE.
DURHAM, NC 27705

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
39			3

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

SUSAN FONTENOT
10717 DAPPLE GREY LANE
CHARLOTTE, NC 28213

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
24			3

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

ROSETTA LISSA CAPPS
1717 FOX HOLLOW
YORK, SC 29745

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
21			3

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

PHIL COLEMAN
18908 RIVERWIND LANE
DAVIDSON, NC 28036

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
11			3

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

INSYNC BENEFITS, INC
P.O. BOX 1474
CORNELIUS, NC 28031

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
9	1	BROKER BONUS	3

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

NANCY BAUCOM
940-12 JETTON ST
DAVIDSON, NC 28036

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
7			3

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

TIMOTHY COBB
116 SPINEL LN
KNIGHTGALE, NC 27545

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
6			3

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

BRIAN FLANNERY
183 WINDSOR GREEN DRIVE
CLAYTON, NC 27527

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
4			3

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

LYNN M. MCLEOD
165 MCDOWELL
MILLS RIVER, NC 28759

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
4			3

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

JULIAN EMERSON
PO BOX 598
GEORGETOWN, SC 29442

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1	2	BROKER BONUS	3

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

WHICKER PARTNERSHIPS INC.
215 ESSEX FARM RD.
ADVANCE, NC 27006

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2			3

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

BARRETT L. PATTERSON
1522 DELLWOOD DRIVE
RALEIGH, NC 27605

(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

BARBARA C. FAW
507 HAMBY MOUNTAIN ROAD
PURLEAR, NC 28665

(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

HOBART BRADLEY MCCOLLUM
1020 N GLOSTER ST. #250
TUPELO, MS 38804

(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

ROBERT W. FOXWORTH INC.
217 BRANCHSIDE
HOLLY SPRINGS, NC 27540

(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

TRIAD BENEFITS GROUP INC

200 DOLLY LANE
WINSTON SALEM, NC 27107

(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

(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)**	0
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)**	0
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) ▶ VOLUNTARY SUPPLEMENTAL BENEFITS

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**	76421
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 ☒ 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 10/01/2019 and ending 09/30/2020

A Name of plan
CENTRAL FLORIDA MOTOR SALES, INC. FLEXIBLE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
CENTRAL FLORIDA MOTOR SALES, INC.

D Employer Identification Number (EIN)
27-3500528

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
COLONIAL LIFE & ACCIDENT 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
57-0144607	62049	E4187134	79	08/01/2019	07/31/2020

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
14818	2891

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

INSURANCE OFFICE OF AMERICA
1855 W STATE ROAD #434
LONGWOOD, FL 32750

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
6940			3

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

WORKSITE BENEFITS SOLUTION, LLC
1009 VERONA ST.
KISSIMMEE, FL 34741

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
2002	1363	BROKER BONUS	3

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

FAITH CRYSTAL TAYLOR
431 AUSTRALIAN WAY
DAVENPORT, FL 33897

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1249	222	BROKER BONUS	3

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

SARAH WEYMOUTH
306 MAPLE AVE
KISSIMMEE, FL 34741

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1059	393	BROKER BONUS	3

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

BIANCA NAVARRO
8005 HEMINGWAY CIRCLE
HAINES CITY, FL 33844

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
822	225	BROKER BONUS	3

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

CALVON Y. BUCZKOWSKI
2608 TALL MAPLE LOOP
OCOEE, FL 34761

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
524	289	BROKER BONUS	3

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

KENNETH A. HOLDER
870 GREENSHANK DRIVE
HAINES CITY, FL 33844

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
679	57	BROKER BONUS	3

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

JENNIFER WEYMOUTH RESMONDO
2940 OAKTREE DR
KISSIMMEE, FL 34744

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
437	132	BROKER BONUS	3

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

LAURA CECILIA MEDINA
13106 SAN ANTONIO WOODS LANE
ORLANDO, FL 32824

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
351	5	BROKER BONUS	3

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

MICHAEL G. BOYCE
2622 WYMAN CIRCLE
KISSIMMEE, FL 34744

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
111	112	BROKER BONUS	3

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

OMAR ENRIQUE FIGUEROA
3424 DOUGLAS CT.
KISSIMMEE, FL 34746

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
183	22	BROKER BONUS	3

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

SAMANTHA C. CORTELAZZO-ABBATE
1283 TWIN RIVERS BLVD
OVIEDO, FL 32766

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
133			3

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

DEANNA BOUFFORD
406 MAHOGANY RIDGE DRIVE
DAVENPORT, FL 33897

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
99			3

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

EMPLOYEE BENEFITS GROUP OF FLORIDA
1924 DOWN HOLLOW LANE
WINDERMERE, FL 34786

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
41	56	BROKER BONUS	3

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

WALTER E. MARTINEZ
1023 VALENCIA TOWN TERRACE
ORLANDO, FL 32825

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
76			3

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

DEBRA DAIGLE AMOEDO
12750 GRECO DRIVE
ORLANDO, FL 32824

(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

THE MEEHAN AGENCY LLC
1924 DOWN HOLLOW LANE
WINDERMERE, FL 34786

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
15	10	BROKER BONUS	3

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

ANGEL GABRIEL VELAZQUEZ-DIAZ
2022 ESTANCIA CIR, SUITE 6
KISSIMMEE, FL 34741

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
19	3	BROKER BONUS	3

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

COLLETTE G. BOISVERT
349 CENTRAL STREET
MANCHESTER, NH 03103

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
17			3

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

MARCOS MATOS
4417 13TH STREET
ST CLOUD, FL 34769

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
11	1	BROKER BONUS	3

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

ROBERT SHAVERS
13716 HAWKEYE DRIVE
ORLANDO, FL 32837

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
10			3

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

BARBARA C. BRENLOVE
P.O. BOX 470701
CELEBRATION, FL 34747

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
7			3

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

TANYA AUSTIN VALENTE
3267 HAWKS NEST DRIVE
KISSIMMEE, FL 34741

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

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

GINAKES & ASSOCIATES, LLC
1020 WEST INTERNATIONAL SPEEDWAY
DAYTONA BEACH, FL 32114

(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

CORCORAN & HOYT LLC
3905 TAMPA ROAD
OLDSMAR, FL 34677

(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

(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)**	0
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)**	0
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) ▶ VOLUNTARY SUPPLEMENTAL BENEFITS

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**	40055
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 10/01/2019 and ending 09/30/2020

A Name of plan
CENTRAL FLORIDA MOTOR SALES, INC. FLEXIBLE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
CENTRAL FLORIDA MOTOR SALES, INC.

D Employer Identification Number (EIN)
27-3500528

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
COLONIAL LIFE & ACCIDENT 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
57-0144607	62049	E3995479	161	08/01/2019	07/31/2020

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
39443	7213

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

INSURANCE OFFICE OF AMERICA
1855 W STATE ROAD #434
LONGWOOD, FL 32750

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
18389			3

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

WORKSITE BENEFITS SOLUTION, LLC
1009 VERONA ST.
KISSIMMEE, FL 34741

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
5529	3486	BROKER BONUS	3

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

FAITH CRYSTAL TAYLOR
431 AUSTRALIAN WAY
DAVENPORT, FL 33897

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
3700	641	BROKER BONUS	3

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

SARAH WEYMOUTH
306 MAPLE AVE
KISSIMMEE, FL 34741

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2798	947	BROKER BONUS	3

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

CALVON Y. BUCZKOWSKI
2608 TALL MAPLE LOOP
OCOEE, FL 34761

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1424	771	BROKER BONUS	3

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

BIANCA NAVARRO
8005 HEMINGWAY CIRCLE
HAINES CITY, FL 33844

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1495	406	BROKER BONUS	3

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

OMAR ENRIQUE FIGUEROA
3424 DOUGLAS CT.
KISSIMMEE, FL 34746

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1460	175	BROKER BONUS	3

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

JENNIFER WEYMOUTH RESMONDO
2940 OAKTREE DR
KISSIMMEE, FL 34744

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1217	354	BROKER BONUS	3

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

KENNETH A HOLDER
870 GREENSHANK DRIVE
HAINES CITY, FL 33844

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
860	58	BROKER BONUS	3

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

MARCOS MATOS
4417 13TH STREET
ST CLOUD, FL 34769

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
666	48	BROKER BONUS	3

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

ANGEL GABRIEL VELAZQUEZ-DIAZ
2022 ESTANCIA CIR, SUITE 6
KISSIMMEE, FL 34741

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
254	76	BROKER BONUS	3

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

EMPLOYEE BENEFITS GROUP OF FLORIDA
1924 DOWN HOLLOW LANE
WINDERMERE, FL 34786

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
119	162	BROKER BONUS	3

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

DEBRA DAIGLE AMOEDO
12750 GRECO DRIVE
ORLANDO, FL 32824

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
259	5	BROKER BONUS	3

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

CARUSO INSURANCE BENEFITS INC
10872 WILDERNESS CT.
ORLANDO, FL 32821

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
212			3

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

ROBERT SHAVERS
13716 HAWKEYE DRIVE
ORLANDO, FL 32837

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
183			3

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

LAURA CECILIA MEDINA
13106 SAN ANTONIO WOODS LANE
ORLANDO, FL 32824

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
139	2	BROKER BONUS	3

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

GIOMARIS IRZARRY-SANTIAGO
14238 FREDRICKSBURG DR #320
ORLANDO, FL 32837

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
121	4	BROKER BONUS	3

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

SAMANTHA C. CORTELAZZO-ABBATE
1283 TWIN RIVERS BLVD
OVIEDO, FL 32766

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
105			3

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

WALTER E. MARTINEZ
1023 VALENCIA TOWN TERRACE
ORLANDO, FL 32825

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
97			3

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

MICHAEL G. BOYCE
2622 WYMAN CIRCLE
KISSIMMEE, FL 34744

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
49	36	BROKER BONUS	3

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

GINAKES & ASSOCIATES, LLC
1020 WEST INTERNATIONAL SPEEDWAY
DAYTONA BEACH, FL 32114

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
67	3	BROKER BONUS	3

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

COLLETTE G. BOISVERT
349 CENTRAL STREET
MANCHESTER, NH 03103

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
69			3

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

THE MEEHAN AGENCY LLC
1924 DOWN HOLLOW LANE
WINDERMERE, FL 34786

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
41	28	BROKER BONUS	3

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

MARGIE LEE SHELDON
325 EUNICE ROAD
LAKELAND, FL 33803

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
40			3

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

SANDRA SIMS
13750 W. COLONIAL DRIVE STE. 350
WINTER GARDEN, FL 34787

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
36			3

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

SABRINA S. RAMOS
13750 W. COLONIAL DRIVE
WINTER GARDEN, FL 34787

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
36			3

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

CORCORAN & HOYT LLC
3905 TAMPA ROAD
OLDSMAR, FL 34677

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
19	8	BROKER BONUS	3

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

BARBARA C. BRENLOVE

P.O. BOX 470701
CELEBRATION, FL 34747

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
19			3

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

DEANNA BOUFFORD

406 MAHOGANY RIDGE DRIVE
DAVENPORT, FL 33897

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
13			3

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

CONSTANCE LABONTE

4824 WILLOW RIDGE TERRACE
VALRICO, FL 33594

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
11			3

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

BRIAN R CHOWNING

36241 S. GRAYS AIRPORT RD
FRUITLAND PARK, FL 34731

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
5	2	BROKER BONUS	3

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

WYNCIN P. MARTIN

214 BALBOA DR.
KISSIMMEE, FL 34758

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
6			3

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

TANYA AUSTIN VALENTE
3267 HAWKS NEST DRIVE
KISSIMMEE, FL 34741

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
4	1	BROKER BONUS	3

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

RODERICK A. SENIOR
11820 SWEET PEA CT
TAMPA, FL 33635

(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

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

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)**	0
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)**	0
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) ▶ VOLUNTARY SUPPLEMENTAL BENEFITS

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**	120421
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 10/01/2019 and ending 09/30/2020

A Name of plan
CENTRAL FLORIDA MOTOR SALES, INC. FLEXIBLE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
CENTRAL FLORIDA MOTOR SALES, INC.

D Employer Identification Number (EIN)
27-3500528

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
GUARDIAN

(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	00514819	442	08/01/2019	07/31/2020

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
34163	10844

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

INSURANCE OFFICE OF AMERICA
1855 W STATE ROAD #434
LONGWOOD, FL 32750

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
34163	10844	BROKER BONUS	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	

(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)**	0
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)**	0
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** [X] 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** [ ] 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**	393951
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 10/01/2019 and ending 09/30/2020

A Name of plan
CENTRAL FLORIDA MOTOR SALES, INC. FLEXIBLE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
CENTRAL FLORIDA MOTOR SALES, INC.

D Employer Identification Number (EIN)
27-3500528

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
CIGNA HEALTH AND 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
59-1031071	67369	3342853	394	08/01/2019	07/31/2020

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
119386	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

INSURANCE OFFICE OF AMERICA
1855 W STATE ROAD #434
LONGWOOD, FL 32750

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
119386			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	
			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)**	0
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)**	0
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** [X] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [X] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	1707438		
(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)**	1707438
b Benefit charges (1) Claims paid	**9b(1)**	1975609		
(2) Increase (decrease) in claim reserves	**9b(2)**	244861		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	2220470
(4) Claims charged			**9b(4)**	2220470
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	102446		
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**	122318		
(E) Taxes	**9c(1)(E)**	29883		
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	254647
(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)**	244861
(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**	368905
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 C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2019** **This Form is Open to Public Inspection.**

For calendar plan year 2019 or fiscal plan year beginning 10/01/2019 and ending 09/30/2020

A Name of plan
CENTRAL FLORIDA MOTOR SALES, INC. FLEXIBLE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
CENTRAL FLORIDA MOTOR SALES, INC.

D Employer Identification Number (EIN)
27-3500528

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . ☐ Yes ☒ No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

CIGNA HEALTH AND LIFE INSURANCE CO.

59-1031071

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 31 38 49 50 56 62	CLAIM ADMINISTRATION ETC.	100	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	**(c)** Relationship to employer, employee organization, or person known to be a party-in-interest	**(d)** Enter direct compensation paid by the plan. If none, enter -0-.	**(e)** Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	**(f)** Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	**(g)** Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	**(h)** Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	**(c)** Relationship to employer, employee organization, or person known to be a party-in-interest	**(d)** Enter direct compensation paid by the plan. If none, enter -0-.	**(e)** Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	**(f)** Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	**(g)** Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	**(h)** Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	**(c)** Relationship to employer, employee organization, or person known to be a party-in-interest	**(d)** Enter direct compensation paid by the plan. If none, enter -0-.	**(e)** Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	**(f)** Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	**(g)** Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	**(h)** Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
AMERICAN SPECIALTY HEALTH 10221 WATERIDGE CIR 201 SAN DIEGO, CA 92121 33-0571188	INDIRECT COMPENSATION RECEIVED BY CIGNA FROM THIS VENDOR TO DEFRAY CIGNA'S INFRASTRUCTURE AND OTHER COST TO IMPLEMENT AND ADMINISTER ON AN ONGOING BASIS THE EXPANDED ACCESS TO THE PHYSICAL THERAPY, AND OCCUPATIONAL THERAPY PROVIDER NETWORK/DISCOUNTS.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
CASTLIGHT HEALTH 121 SPEAR STREET, 3RD FLOOR SAN FRANCISCO, CA 94105 26-1989091	INDIRECT COMPENSATION RECEIVED BY CIGNA FROM THIS VENDOR (I) TO DEFRAY CIGNA'S COST FOR THE INFRASTRUCTURE CHANGES REQUIRED TO FACILITATE IMPLEMENTATION OF THIS VENDOR'S CUSTOMER TRANSPARENCY AND ENGAGEMENT SERVICES; (II) AS REIMBURSEMENT FOR ANNUAL

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
LIVONGO 444 N. MICHIGAN, SUITE 3400 CHICAGO, IL 60611 26-3542036	INDIRECT COMPENSATION RECEIVED BY CIGNA FROM THIS VENDOR TO DEFRAY CIGNA'S INFRASTRUCTURE AND OTHER COST TO IMPLEMENT AND ADMINISTER ON AN ONGOING BASIS ACCESS TO THE VENDOR'S DIABETES CARE MANAGEMENT SERVICES. YOUR PLAN PARTICIPANTS MAY HAVE RECEIVE

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
OMADA HEALTH, INC. 500 SANSOME ST., 200 SAN FRANCISCO, CA 94111 45-2355015	DIGITAL DIABETES PREVENTIVE CARE SERVICES PROVIDER- INDIRECT COMPENSATION RECEIVED BY CIGNA FROM THIS PROVIDER FOR SERVICES INCLUDING: (I) EXPLAINING THE OMADA SERVICES TO EXISTING AND PROSPECTIVE CLIENTS; (II) ENCOURAGING AT-RISK INDIVIDUALS WHO MAY

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
VISION SERVICE PLAN 333 QUALITY DRIVE RANCHO CORDOVA, CA 96670 06-1227840	VENDOR FOR VISION SERVICES - INDIRECT COMPENSATION RECEIVED BY CIGNA FROM THIS VENDOR FOR CIGNA'S EXPENSES ASSOCIATED WITH ADMINISTERING PLANS WITH VISION BENEFITS. FOR CALENDAR YEAR 2019, CIGNA RECEIVED INDIRECT COMPENSATION FROM THIS VENDOR OF APPR

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
BANK OF AMERICA 540 WEST MADISON STREET CHICAGO, IL 60661 94-1687665	EARNINGS CREDITS ASSOCIATED WITH BANK ACCOUNTS UTILIZED BY CIGNA IN THE ADMINISTRATION OF CLAIM OVERPAYMENT RECOVERIES. APPLICABLE TO ALL SELF-FUNDED PLANS ADMINISTERED BY CIGNA. FOR CALENDAR YEAR 2019, CIGNA RECEIVED INDIRECT COMPENSATION FROM THIS

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
AMPLIFON HEARING HEALTHCARE 150 SOUTH STREET, SUITE 2300 MINNEAPOLIS, MN 55402 85-0437037	VOLUME BASED MARKETING FEES PAID BY VENDORS PARTICIPATING IN THE CIGNA HEALTHY REWARDS PROGRAM WHICH OFFERS PLAN PARTICIPANTS DISCOUNTS ON VARIOUS SERVICES. APPLICABLE TO YOUR PLAN IF YOUR PLAN PARTICIPANTS HAVE A CIGNA ID CARD AND ACCESS TO MYCIGNA.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
FIT FOR LIFE 833 W SOUTH BOULDER RD LOUISVILLE, CO 80027 38-3983812	VOLUME BASED MARKETING FEES PAID BY VENDORS PARTICIPATING IN THE CIGNA HEALTHY REWARDS PROGRAM WHICH OFFERS PLAN PARTICIPANTS DISCOUNTS ON VARIOUS SERVICES. APPLICABLE TO YOUR PLAN IF YOUR PLAN PARTICIPANTS HAVE A CIGNA ID CARD AND ACCESS TO MYCIGNA.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.		0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
CITIBANK NA ONE PENNS WAY NEW CASTLE, DE 19720 13-5266470	EARNINGS CREDITS ON DAILY FUND BALANCES ASSOCIATED WITH BANK ACCOUNTS UTILIZED IN THE CLAIM ADMINISTRATION BY CIGNA. APPLICABLE TO ALL SELF-FUNDED PLANS UTILIZING CITIBANK SERVICES. FOR CALENDAR YEAR 2019, CIGNA RECEIVED INDIRECT COMPENSATION FROM TH

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
CITIBANK NA (CHLIC CORE DEPO ONE PENNS WAY NEW CASTLE, DE 19720 59-1031071	EARNINGS CREDITS ON DAILY FUND BALANCES ASSOCIATED WITH BANK ACCOUNTS UTILIZED IN THE CLAIM ADMINISTRATION BY CIGNA. APPLICABLE TO ALL SELF-FUNDED PLANS FOR CIGNA BEHAVIORAL HEALTH UTILIZING CITIBANK SERVICES. FOR CALENDAR YEAR 2019, CIGNA RECEIVED I

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
CITIBANK NA (OMNIBUS) ONE PENNS WAY NEW CASTLE, DE 19720 13-5266470	EARNINGS CREDITS ON DAILY FUND BALANCES ASSOCIATED WITH BANK ACCOUNTS UTILIZED IN THE CLAIM ADMINISTRATION BY CIGNA. APPLICABLE TO ALL SELF-FUNDED PLANS FOR CIGNA BEHAVIORAL HEALTH UTILIZING CITIBANK SERVICES. FOR CALENDAR YEAR 2019, CIGNA RECEIVED I

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
DEUTSCHE BANK 60 WALL STREET NEW YORK, NY 10005 13-4941247	EARNINGS CREDITS ASSOCIATED WITH BANK ACCOUNTS UTILIZED BY CIGNA IN THE ADMINISTRATION OF DISBURSING CLAIM REFUNDS. APPLICABLE TO ALL SELF-FUNDED PLANS ADMINISTERED BY CIGNA. FOR CALENDAR YEAR 2019, CIGNA RECEIVED INDIRECT COMPENSATION FROM THIS VEND

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
JPMORGAN CHASE 3 CHASE METRO TECH CENTER, 5TH FL BROOKLYN, NY 11245 13-4994650	EARNINGS CREDITS ON DAILY FUND BALANCES ASSOCIATED WITH BANK ACCOUNTS UTILIZED IN CLAIM ADMINISTRATION BY CIGNA. APPLICABLE TO ALL SELF-FUNDED PLANS UTILIZING JPMORGAN CHASE SERVICES. FOR CALENDAR YEAR 2019, CIGNA RECEIVED INDIRECT COMPENSATION FROM

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.		0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
SAGAMORE NETWORK HOSPITALS	NETWORK HOSPITALS HAVE CONTRACTED WITH SAGAMORE HEALTH NETWORK TO PAY NETWORK ADMINISTRATION FEES. FOR CALENDAR YEAR 2019, CIGNA RECEIVED INDIRECT COMPENSATION FROM THIS VENDOR OF APPROXIMATELY $.09 PER PARTICIPANT.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

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 10/01/2019 and ending 09/30/2020

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 instr.)
- ☒ 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
CENTRAL FLORIDA MOTOR SALES, INC.
FLEXIBLE BENEFITS PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 10/01/1996

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)
CENTRAL FLORIDA MOTOR SALES, INC.
D/B/A TOYOTA OF ORLANDO

3575 VINELAND ROAD

ORLANDO FL 32811-6435

2b Employer Identification Number (EIN) 27-3500528

2c Plan Sponsor's telephone number 407-298-4500

2d Business code (see instructions) 441110

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	[signature]	7/12/2021	R. TODD BOBO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	[signature]	7/12/2021	R. TODD BOBO
	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

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

Form 5500 (2019)
v. 190130

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	693
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)	693
a (2) Total number of active participants at the end of the plan year	6a(2)	703
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	703
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f Total. Add lines **6d** and **6e**	6f	
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 4E 4F 4H 4Q

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) [X] Insurance	(1) [X] Insurance
(2) [ ] Code section 412(e)(3) insurance contracts	(2) [ ] Code section 412(e)(3) insurance contracts
(3) [ ] Trust	(3) [ ] Trust
(4) [ ] General assets of the sponsor	(4) [ ] General assets of the sponsor

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) [X] **C** (Service Provider Information)

(5) [ ] **D** (DFE/Participating Plan Information)

(6) [ ] **G** (Financial Transaction Schedules)