Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2020

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

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

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
TRIANGLE FASTENER CORPORATION MEDICAL PLAN

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 01/01/1992

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)
TRIANGLE FASTENER CORPORATION

1925 PREBLE AVENUE
PITTSBURGH, PA 15233

2b Employer Identification Number (EIN) 25-1323633

2c Plan Sponsor's telephone number 412-321-5021

2d Business code (see instructions) 423300

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.	09/22/2021	MELISSA A. MATHIS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.		
	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**	204
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)**	
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	212
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**	212
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

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] 4 **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 2020 Form M-1 annual report. If the plan was not required to file the 2020 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2020

This Form is Open to Public Inspection

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

A Name of plan
TRIANGLE FASTENER CORPORATION MEDICAL PLAN

B Three-digit plan number (PN) ▶ 502

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

D Employer Identification Number (EIN)
25-1323633

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
13-5123390	64246	00369613	212	01/01/2020	12/31/2020

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
11942	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

HHM BENEFITS SERVICES LLC
500 COMMERCE DRIVE, PO BOX 1138
MOON TOWNSHIP, PA 15108

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
11942			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	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** [X] Other (specify) ▶ AD & D

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**	135310
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2020

This Form is Open to Public Inspection

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

A Name of plan
TRIANGLE FASTENER CORPORATION MEDICAL PLAN

B Three-digit plan number (PN) ▶ 502

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

D Employer Identification Number (EIN)
25-1323633

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	00612553	193	01/01/2020	12/31/2020

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
77206	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

HHM BENEFITS SERVICES LLC
500 COMMERCE DRIVE, PO BOX 1138
MOON TOWNSHIP, PA 15108

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
77206			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	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** [ ] 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**	625187
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2020

This Form is Open to Public Inspection

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

A Name of plan
TRIANGLE FASTENER CORPORATION MEDICAL PLAN

B Three-digit plan number (PN) ▶ 502

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

D Employer Identification Number (EIN)
25-1323633

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
AFLAC

(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
82-2723296	60380	Q4190	48	01/01/2020	12/31/2020

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
3385	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
VARIOUS-SEE ATTACHED PDF

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
3385			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	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** [ ] 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**	33493
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2020

This Form is Open to Public Inspection

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

A Name of plan
TRIANGLE FASTENER CORPORATION MEDICAL PLAN

B Three-digit plan number (PN) ▶ 502

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

D Employer Identification Number (EIN)
25-1323633

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 & ACCIDENTAL 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	E7053101	6	01/01/2020	12/31/2020

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
404	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
VARIOUS-SEE ATTACHED PDF

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
404			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** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [X] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	5084
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.**	**2020** **This Form is Open to Public Inspection.**

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

A Name of plan
TRIANGLE FASTENER CORPORATION MEDICAL PLAN

B Three-digit plan number (PN) ▶ 502

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

D Employer Identification Number (EIN)
25-1323633

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).. . . . . [X] 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

AMERICAN SPECIALTY HEALTH
10221 WATERIDGE CIR 201
SAN DIEGO, CA 92121

33-0571188

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

AMPLIFON HEARING HEALTHCARE
150 SOUTH 5TH STREET, STE. 2300
MINNEAPOLIS, MN 55402

85-0437037

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

OMADA HEALTH INC.
500 SANSOME ST., 200
SAN FRANCISCO, CA 94111

45-2355015

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

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

(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

(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)

(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 ☐

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

(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.

(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.

(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:

*Amounts provided under the "Commissions Paid" column include all earne d commission paid on all lines of business relative to your account during this reporting period.
**Amounts provided under the "Fees Paid" column include the total value of any fees, awards, prize s, bonuses or other forms of non-monetary compensation paid relative to your account. These amounts are calcula ted based on a calendar year. Some bonuses, fees, and contests are paid based on the aggregate amount of s ales for all accounts throughout the calendar year. To determine the value of these items rel ative to your account, the amount of sales for your account is divided by the total amount of sales during the reporting period. This percentage is then multiplied by the value of the bonus, fee or contest.

SCHEDULE A EARNINGS REPORT

Group Number	Total Premium Collected	Group Covered Count
Q4190	$33,492.78	48

Group Address	Name of Insurance Carrier
TRIANGLE FASTENER CORP	AFLAC
ATTN CHARLES SUMNER	1932 WYNNTON ROAD
2295 PREBLE AVE	COLUMBUS, GA 31999
PITTSBURGH, PA 00001-5233	**PLAN YEAR 01/01/2020 to 12/31/2020**
CONTRACT NUMBER	**NAIC CODE**
82-2723296	60380

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
DAVID B RAY 5122 STONEWOOD DR SMYRNA, TN 37167	$283.01	$0.00
- LANCE PITTMAN LLC 125 LITTLE HAWK PL MIDLOTHIAN, VA 23114	$185.38	$0.00
ROBERT MCDOWELL 5300 OAKBROOK PKWY STE 300 NORCROSS, GA 30093	$171.60	$0.00
KORNELIJA NUMIC 17621 17TH ST TUSTIN, CA 92780	$128.44	$0.00
CHARLES M TRULUCK 20311 UPLAND FAIR LN KATY, TX 77449	$124.28	$0.00

JOYCE A ELLIOTT 36814 TEAL RD MILLSBORO, DE 19966	$118.94	$0.00
MARLENE GONZALEZ WANZONG 14407 WHISPERING VALLEY DR CYPRESS, TX 77429	$112.20	$0.00
RHONDA NEWMAN 432 SEVERIN AVE MODESTO, CA 95354	$85.67	$0.00
JOHN B LACARIA 102 JENNIFER LN BRIDGEPORT, WV 26330	$82.99	$0.00
CHARLES HUGH MACKAY 2383 S MAIN ST STE B100 AKRON, OH 44319	$76.15	$0.00
FELICIA BAKER 2819 N PARHAM RD STE 240 RICHMOND, VA 23294	$70.84	$0.00
SUE B KLINE 413 OLD TOWNE DR BRENTWOOD, TN 37027	$62.40	$0.00
DAVID J ROTH 800 ROCKMEAD DR STE 208 KINGWOOD, TX 77339	$58.63	$0.00
CAROL S JACKSON PO BOX 1550 MILLBROOK, AL 36054	$56.81	$0.00
TERESITA M GARCIA MENDOZA 3051 NE 47TH CT APT 308 FORT LAUDERDALE, FL 33308	$53.30	$0.00
JAMES C ZOMBRO 625 COUNTY ROAD 106 FLORENCE, AL 35633	$52.78	$0.00
NANCY E WELCH 4209 LAKELAND DR 369 FLOWOOD, MS 39232	$47.45	$0.00
RONALD A DASHKOVITZ 20 MILLPOND TRL SAGINAW, MI 48603	$46.41	$0.00
KENNETH S BIRNBAUM 3000 CHESTNUT AVE STE 323 BALTIMORE, MD 21211	$45.89	$0.00
JAMES M LONG 6147 MOUNTCREEK CT NORCROSS, GA 30092	$44.85	$0.00

WILLIAM R REGISTER P O BOX 2386 THOMASVILLE, GA 31799	$42.51	$0.00
BETH A RICHARDSON 899 FLEMING AVE FAIRMONT, WV 26554	$42.43	$0.00
GENIA ANNE TENCH 542 KING WILLIAM RD HANOVER, VA 23069	$41.36	$0.00
DAVID MORNINGSTAR 4281 BUCKSKIN WOOD DR ELLICOTT CITY, MD 21042	$39.91	$0.00
CHAD W HAINES 108 WROXTON DR CONROE, TX 77304	$39.13	$0.00
- RUBICON REGION LLC 1862 KEYSTONE PL SCHAUMBURG, IL 60193	$39.05	$0.00
- ADAM H MICHAELS & ASSOC LTD 2922 CORDA LN LOS ANGELES, CA 90049	$38.48	$0.00
KIMBERELY L SHERRY 14707 VETERANS MEMORIAL HWY REEDSVILLE, WV 26547	$37.31	$0.00
BRYAN FISH 4050 CANDLE LIGHT DR DAYTON, MD 21036	$36.66	$0.00
DAWN T SUCHECKI 225 S WATER ST WILMINGTON, NC 28401	$36.01	$0.00
MARLENE GONZALEZ WANZONG 24018 FARMSTEAD DR HOCKLEY, TX 77447	$33.66	$0.00
- SAIC INC 1639 BRADLEY PARK DR ST 500 BOX 358 COLUMBUS, GA 31904	$32.50	$0.00
JEAN CLAUDE FRESNEL JR 700 12TH ST NW STE 700 WASHINGTON, DC 20005	$32.11	$0.00
ABBIE W COFFMAN 31 HAWTHORN CIR CROSSVILLE, TN 38555	$31.07	$0.00

RANDY B JACKSON PO BOX 1550 MILLBROOK, AL 36054	$30.81	$0.00
GEORGE J CERCEO 4108 MILLTOWN TRL DOWNINGTOWN, PA 19335	$30.22	$0.00
JOHANNA R GRIFFIN 341 WOODFORD DR MILLBROOK, AL 36054	$30.08	$0.00
CHRISTOPHER C HAYWARD PO BOX 30668 PALM BEACH GARDENS, FL 33420	$30.03	$0.00
RYAN A DREBING 2112 N ROAN ST STE 702 JOHNSON CITY, TN 37601	$29.51	$0.00
MATTHEW SUTTON 2318 LEGENDS SHORE DR SPRING, TX 77386	$27.43	$0.00
KEITH LIN BELICH 8408 TIMBER CREEK DR PIKE ROAD, AL 36064	$26.80	$0.00
ALBERT J WELCH III 4209 LAKELAND DR 369 FLOWOOD, MS 39232	$25.74	$0.00
RONALD NEWMAN 1305 IPSWICH DR BEL AIR, MD 21014	$25.35	$0.00
- GSL MARKETING INC PO BOX 358198 GAINESVILLE, FL 32635	$24.70	$0.00
LORI J THOMPSON 625 HARBOR POINT CT LAWRENCEVILLE, GA 30044	$23.53	$0.00
BRIAN K CHAMBERS 8 NIGHTWIND CT COLUMBUS, GA 31909	$23.22	$0.00
LARA K CARLSON 106 LAUREL VIEW DR ST SIMONS ISLAND, GA 31522	$21.45	$0.00
NANCY E ODOM 5921 STONE MEADOW DR PLANO, TX 75093	$20.93	$0.00
JOHN T CAPOZZI 242 WICKERBERRY DR MIDDLETOWN, DE 19709	$20.60	$0.00

- THE PERRY GROUP INC 1650 SAND LAKE RD STE 201D ORLANDO, FL 32809	$20.15	$0.00
ADRIANNE NICHOLE HATLEY PO BOX 722 WYTHEVILLE, VA 24382	$18.98	$0.00
ROBERT P CARTER 95 BERKSHIRE DR FALLING WATERS, WV 25419	$17.68	$0.00
THOMAS J MCCORD 10 SCOTT AVE MORGANTOWN, WV 26508	$17.30	$0.00
JEFFREY C WEST 2466 FM 1697 LEDBETTER, TX 78946	$15.86	$0.00
SUWAT ASSAWAMATIYANONT 8171 HAMPTON WOOD DR BOCA RATON, FL 33433	$15.47	$0.00
SHANNON PITTS 4115 COLUMBIA RD STE 5PMB198 MARTINEZ, GA 30907	$15.08	$0.00
JAMES C FARMER JR 641 OLD HICKORY BLVD UNIT 60 BRENTWOOD, TN 37027	$14.95	$0.00
DOMINICK J LACARIA JR 110 BETHANY DR MCMURRAY, PA 15317	$13.58	$0.00
D P SMITH 519 SHALOM WAY FLOWOOD, MS 39232	$13.52	$0.00
MATTHEW W EVANS 1344 ASHTON RD STE 200 HANOVER, MD 21076	$13.13	$0.00
FELICIA BAKER 804 MOOREFIELD PARK DR STE 108 RICHMOND, VA 23236	$12.88	$0.00
CHARLES P SHETTLE 1400 BATTERY AVE BALTIMORE, MD 21230	$12.87	$0.00
MEREDITH K SCHAEFER 1011 HARBERT ST TALLAHASSEE, FL 32303	$12.87	$0.00
GEORGE LEE WASHINGTON 2518 DULUTH HIGHWAY 120 STE 202 DULUTH, GA 30097	$12.74	$0.00

CLARENCE E (GENE) DANNELLY 20110 AMBERVINE CIRCLE KATY, TX 77450	$11.44	$0.00
JOHN M JOHNSON 2150 W NORTHWEST HWY STE 114-1144 GRAPEVINE, TX 76051	$11.05	$0.00
WILLIAM M WARDLAW JR 5300 OAKBROOK PKWY STE 300 NORCROSS, GA 30093	$10.86	$0.00
THOMAS J LACARIA 950 MALABAR RD SW UNIT 110519 PALM BAY, FL 32911	$10.79	$0.00
THOMAS J MCCORD 36 MULBERRY LN BRIDGEPORT, WV 26330	$10.44	$0.00
THOMAS W KELLY JR 4001 TARKLE RIDGE DR KITTY HAWK, NC 27949	$10.14	$0.00
GEORGE G DICKEY PO BOX 2575 CONWAY, AR 72033	$9.88	$0.00
CRYSTAL L MARTIN 57 LAVISTA DR MORGANTOWN, WV 26508	$9.75	$0.00
- E SPEED INC 129 GLENWOOD BND MADISON, MS 39110	$9.75	$0.00
CAROLINE D MORNINGSTAR 4281 BUCKSKIN WOOD DR ELLICOTT CITY, MD 21042	$9.49	$0.00
JOHN A DONALDSON 2004 98 PALMS BLVD UNIT 4336 DESTIN, FL 32541	$9.36	$0.00
RICHARD A KRASKI SR 1506 FALLOWFIELD AVE PITTSBURGH, PA 15216	$9.24	$0.00
KATHY J PERKINS 507 EDGEWATER BRANCH DR BRANDON, MS 39042	$8.40	$0.00
NICHOLAS WAGNER 1508 BACK COVE RD VIRGINIA BEACH, VA 23454	$8.06	$0.00
EVERETT C BICKEL 6310 SW 103RD LN OCALA, FL 34476	$7.80	$0.00

DREW SKIBITSKY 1344 ASHTON RD STE 200 HANOVER, MD 21076	$7.56	$0.00
JOHN W DRAY 123 THOMAS RD MCMURRAY, PA 15317	$7.09	$0.00
LARRY W FLOWERS 930 WOODLAND SAUTEE NACOOCHEE, GA 30571	$6.76	$0.00
CHARLES BRITT BERRIER JR 640 CEDAR LN CANA, VA 24317	$6.75	$0.00
ROBERT L TRAPNELL JR 15 N INDIAN RIVER DR APT 705 COCOA, FL 32922	$6.51	$0.00
ANGELA WOODHAM 23 TABERNACLE RD HOPE HULL, AL 36043	$6.48	$0.00
CYNTHIA M WIMER 4440 LENNI CIR EMMAUS, PA 18049	$6.37	$0.00
- J W GRIMES INC 6165 WATERFORD RD COLUMBUS, GA 31904	$6.37	$0.00
JAN HAMBY ALDAMUY 2031 MONTEGO CT OLDSMAR, FL 34677	$6.11	$0.00
JOEY C ADAMS 317 NORTHEAST 36TH AVE STE 6 OCALA, FL 34470	$6.00	$0.00
BLAINE J LUSHUTE 2625 LAKEWAY DR SEABROOK, TX 77586	$5.98	$0.00
KANDI H HECKLER 5453 HASELL DR ROCKVALE, TN 37153	$5.98	$0.00
GENIA ANNE TENCH 804 MOOREFIELD PARK DR STE 108 RICHMOND, VA 23236	$5.66	$0.00
BRADLEY S JONES 19 BRITISH AMERICAN BLVD W LATHAM, NY 12110	$5.59	$0.00
JOHN A LECKLITER 10 LINDA LN SEVERNA PARK, MD 21146	$5.20	$0.00

- C HEWITT INC 308 LAKE VILLAGE DR MADISON, MS 39110	$5.07	$0.00
- ASHTON CONSULTING INC 3606 RIDGEVIEW DR STE 200 COLUMBIA, MO 65203	$5.01	$0.00
JEREMY A FELDMAN 12391 HIDDEN BAY DR BERLIN, MD 21811	$4.94	$0.00
KENNETH B COFER 5950 SYMPHONY WOODS ROAD STE 214 COLUMBIA, MD 21044	$4.68	$0.00
- THE DIAMOND AGENCY LLC 2013 OLD RIDGE WAY SUITE 150 #202 LELAND, NC 28451	$4.29	$0.00
- J LEE & ASSOCIATES INC 120 GREENVIEW PL STE 3 RICHLAND, MS 39218	$4.16	$0.00
- USI INSURANCE SERVICES LLC PO BOX 62889 VIRGINIA BEACH, VA 23466	$4.01	$0.00
HILARY RADOLEC 165 CROSSBOW LN GAITHERSBURG, MD 20878	$3.90	$0.00
ANDREA STEARNS PO BOX 323 BETHEL PARK, PA 15102	$3.68	$0.00
HARRY M WIMER III 4440 LENNI CIR EMMAUS, PA 18049	$3.51	$0.00
JEARL D BARNETTE 197 STATE LINE DR GRANTSVILLE, MD 21536	$3.15	$0.00
NORA M FOLKERS 1121 CANE MILL LN BRADENTON, FL 34212	$3.12	$0.00
CHARLES BRITT BERRIER JR PO BOX 722 WYTHEVILLE, VA 24382	$3.00	$0.00
BRIAN CUMPTAN 320 9TH ST STE 200 HUNTINGTON, WV 25701	$2.86	$0.00

FREDERICK L ROSE 3631 PUTTER POINT LN FORT MYERS, FL 33919	$2.64	$0.00
TIFFANY INGRAM WALKER 23611 LITCHFIELD BEND LN KATY, TX 77494	$2.60	$0.00
THOMAS ROBERT GIDDENS PO BOX 2517 KENNESAW, GA 30156	$2.47	$0.00
DOUGLAS J SUCHECKI 1224 PEACOCK AVE STE 205 COLUMBUS, GA 31906	$2.24	$0.00
WESLEY W MCINDOE 115 JODI LN BUTLER, PA 16002	$2.15	$0.00
MARIO HAIFA 216 WARWICK DR PITTSBURGH, PA 15241	$2.09	$0.00
DAVID N MORGAN 906 MERCHANT LEE PL MANAKIN SABOT, VA 23103	$2.08	$0.00
JAMES M PITZ 84 MINK DR CATAULA, GA 31804	$2.08	$0.00
BRIAN W PATTEN 120 MARGUERITE DR STE 101 CRANBERRY TOWNSHIP, PA 16066	$1.87	$0.00
STEVEN J PERRY 1650 SAND LAKE RD STE 201D ORLANDO, FL 32809	$1.82	$0.00
WILLIAM M WARDLAW JR 195 GARFIELD ST SANTA ROSA BEACH, FL 32459	$1.81	$0.00
J C ADAMS INC 5631 NE 31ST TER OCALA FL 34479	$1.80	$0.00
VICKI M BUTLER 105 LONG LEAF PL MADISON, MS 39110	$1.56	$0.00
RONALD H RICHEY 4499 MURFREESBORO RD FRANKLIN, TN 37067	$1.43	$0.00
KIMMON R GUSEMAN 47 E FAYETTE ST UNIT 259 UNIONTOWN, PA 15401	$1.15	$0.00

C R RAMSEY POTTS 25 WEATHERBY CIR SAVANNAH, GA 31405	$0.91	$0.00
BRIAN E HICKS 1327 JEWELL AVE FRANKLIN, TN 37064	$0.78	$0.00
KATHY J PERKINS 316 RED CEDAR DR BRANDON, MS 39047	$0.70	$0.00
DARAN L WYCKOFF PO BOX 31233 SPOKANE, WA 99223	$0.68	$0.00
MARK C LEE 11500 COUNTY LINE RD MIDLAND, GA 31820	$0.65	$0.00
PAULA K COLLINS 11107 BOBCAT PL NE ALBUQUERQUE, NM 87122	$0.65	$0.00
DREW SKIBITSKY 1000 FELL ST APT 627 BALTIMORE, MD 21231	$0.63	$0.00
JAMES G BRANDT 47 MARVIN ST PORT MATILDA, PA 16870	$0.56	$0.00
JOY GRUBE PADGELEK 1195 WASHINGTON PIKE STE 300 BRIDGEVILLE, PA 15017	$0.56	$0.00
- D AND V BUTLER INC 105 LONG LEAF PL MADISON, MS 39110	$0.52	$0.00
J DAVID BUTLER 404 A W PARKWAY PLACE RIDGELAND, MS 39157	$0.52	$0.00
JUSTIN W DAVIS 300 LIVE OAK CT SALEM, VA 24153	$0.52	$0.00
KATHERINE LATIMER 5093 BOONE LINKS LN COLUMBUS, GA 31909	$0.52	$0.00
THOMAS J STEPHENSON 31 STADELMAN CT CARTERSVILLE, GA 30120	$0.52	$0.00
JOHN TODD LEE 322 FARMHOUSE RD ELLERSLIE, GA 31807	$0.39	$0.00

KRISTINE G WYCKOFF PO BOX 31233 SPOKANE, WA 99223	$0.36	$0.00
PAUL B BROUCHOUD 604 MARK DR DEL CITY, OK 73115	$0.36	$0.00
TIMOTHY R QUINLAN 137 SEMICONON LN RENFREW, PA 16053	$0.32	$0.00
AMELIA KAY MORGAN 1904 ELLIS DR MAIDENS, VA 23102	$0.26	$0.00
DAVID J WAGENHEIM 582 WOODBINE AVE TOWSON, MD 21204	$0.26	$0.00
KELLY LYNN FELDMAN 12391 HIDDEN BAY DR BERLIN, MD 21811	$0.26	$0.00
LINDSEY JO MARTIN 1450 N ULMER ST GREENWOOD, AR 72936	$0.26	$0.00
OMER S BASS IV 565 W GATEWAY CT MERRITT ISLAND, FL 32952	$0.13	$0.00
Sum:	$3,385.02	$0.00

Insurance Data for Schedule A Form 5500

AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 THE COMPENSATION DATA IS PROVIDED TO COMPLY WITH VARIOUS REGULATIONS, REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

Name of Carrier: Colonial Life & Accident Insurance Company
Post Office Box 1365
Columbia, SC 29202-1365

Carrier EIN: 57-0144607
Carrier NAIC Code: 62049

Account Name: Triangle Fastener Corp Fbp
Billing Control Number: E7053101
Plan Year Date Range: 01/01/2020 - 12/31/2020

Organization Code For Agents/Producers: 3

Amount for Pre-tax or Employer Paid Premium:	$0.00
Amount for After Tax Paid Premium:	$5,084.14
Total Paid Premium:	$5,084.14

APPROXIMATE NUMBER OF PERSONS COVERED IN DECEMBER 2020: 6

Insurance Fees and Commission Information for Schedule A Form 5500

Agent/Producer Name Address	Amount of Commissions On Pre-Tax Or Employer Paid Policies	Amount of Commissions On After Tax Or Employee Paid Policies	Total Commissions Paid	Amount of Fees Paid If Any
William E Good 545 Tom Sawyer Rd Dripping Springs TX 78620	$0.00	$6.36	$6.36	$0.00
Tammy A Morgart 13347 Dean Drive North Huntingdon PA 15642	$0.00	$10.08	$10.08	$0.00
Edward P Dougherty Inc 4550 Prestwick Dr Reading PA 19606	$0.00	$19.45	$19.45	$0.00
Timothy J Slater 466 Carnegie Drive Pittsburgh PA 15243	$0.00	$5.04	$5.04	$0.00

Agent/Producer Name Address	Amount of Commissions On Pre-Tax Or Employer Paid Policies	Amount of Commissions On After Tax Or Employee Paid Policies	Total Commissions Paid	Amount of Fees Paid If Any
Babb Incorporated 850 Ridge Avenue Pittsburgh PA 15212	$0.00	$63.43	$63.43	$0.00
J O Mcdonald 183 N Broadleigh Rd Columbus OH 43209	$0.00	$2.44	$2.44	$0.00
Joseph Mcdonald 12052 Peppermill Lane Nw Pickerington OH 43147	$0.00	$51.94	$51.94	$0.00
James A Sharp 1021 Tulip Blossom Drive Hermitage TN 37076	$0.00	$20.02	$20.02	$0.00
Bryer Insurance Services Inc 2135 Ridge Road Greensburg PA 15601	$0.00	$23.02	$23.02	$0.00
Grand Totals	$0.00	$201.78	$201.78	$0.00

Certification Statement

Colonial Life & Accident Insurance Company hereby certifies that the enclosed statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate.

Jason Mulligan
AVP of Sales Compensation

Form **5558**
(Rev. September 2018)
Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File Certain Employee Plan Returns

▶ For Privacy Act and Paperwork Reduction Act Notice, see instructions.
▶ Go to www.irs.gov/Form5558 for the latest information.

OMB No. 1545-0212

File With IRS Only

Part I Identification

A Name of filer, plan administrator, or plan sponsor (see instructions)

TRIANGLE FASTENER CORPORATION

Number, street, and room or suite no. (If a P.O. box, see instructions)
1925 PREBLE AVENUE

City or town, state, and ZIP code
PITTSBURGH, PA 15233

B **Filer's identifying number (see instructions)**
Employer identification number (EIN) (9 digits XX-XXXXXXX)
25-1323633

Social security number (SSN) (9 digits XXX-XX-XXXX)

C Plan name	Plan number	Plan year ending - MM	DD	YYYY
TRIANGLE FASTENER CORPORATION MEDICAL PLAN	502	12	31	2020

Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA

1 ☐ Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part I, C above.

2 I request an extension of time until 10/15/2021 to file Form 5500 series. See instructions.

Note: A signature IS NOT required if you are requesting an extension to file Form 5500 series.

3 I request an extension of time until _____ to file Form 8955-SSA. See instructions.

Note: A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.

The application **is automatically approved** to the date shown on line 2 and/or line 3 (above) if **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested; and **(b)** the date on line 2 and/or line 3 (above) is not later than the 15th day of the 3rd month after the normal due date.

Part III Extension of Time To File Form 5330 *(see instructions)*

4 I request an extension of time until _____ to file Form 5330.

You may be approved for up to a 6-month extension to file Form 5330, after the normal due date of Form 5330.

a Enter the Code section(s) imposing the tax ▶ a

b Enter the payment amount attached ▶ b

c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date ▶ c

5 **State in detail why you need the extension:**

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ▶ **Date** ▶

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210 - 0110
1210 - 0089

2020

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

A This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instr.)

B This return/report is: ☒ a single-employer plan ☐ a DFE (specify) _____
☐ 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
TRIANGLE FASTENER CORPORATION MEDICAL PLAN

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 01/01/1992

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)
TRIANGLE FASTENER CORPORATION

1925 PREBLE AVENUE

PITTSBURGH PA 15233

2b Employer Identification Number (EIN) 25-1323633

2c Plan Sponsor's telephone number 412-321-5021

2d Business code (see instructions) 423300

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 of plan administrator	09/22/2021 Date	MELISSA A. MATHIS Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2020)
v. 200204

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	5 204
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)
a(2)	Total number of active participants at the end of the plan year	6a(2) 212
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 212
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

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] 4 A (Insurance Information)
(4) [X] C (Service Provider Information)
(5) [ ] D (DFE/Participating Plan Information)
(6) [ ] G (Financial Transaction Schedules)