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

2021

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

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)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ ☐

Part II Basic Plan Information—enter all requested information

1a Name of plan
HANLEES DEALERSHIP GROUP HEALTH AND WELFARE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 12/01/2009

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)
HANLEES DEALERSHIP GROUP

4640 WESTAMERICA DRIVE
FAIRFIELD, CA 94534

4640 WESTAMERICA DRIVE
FAIRFIELD, CA 94534

2b Employer Identification Number (EIN) 26-1445589

2c Plan Sponsor's telephone number 510-622-4008

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.	07/14/2022	BARBARA MARTINEZ
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:
a Sponsor's name
c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	381
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)**	381
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	331
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**	331
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	331
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4F

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)** [ ] **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 2021 Form M-1 annual report. If the plan was not required to file the 2021 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

2021

This Form is Open to Public Inspection

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

A Name of plan
HANLEES DEALERSHIP GROUP HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
HANLEES DEALERSHIP GROUP

D Employer Identification Number (EIN)
26-1445589

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
WESTERN HEALTH ADVANTAGE

(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
68-0393304		108294	240	01/01/2021	12/31/2021

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
42675	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

AMES-GRENZ INSURANCE SERVICES, INC.
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
42675	0		3

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(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. Specify nature of costs ▶	**6d**	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [X] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [X] 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**	853491
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

2021

This Form is Open to Public Inspection

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

A Name of plan
HANLEES DEALERSHIP GROUP HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
HANLEES DEALERSHIP GROUP

D Employer Identification Number (EIN)
26-1445589

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
KAISER FOUNDATION HEALTH PLAN INC

(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
94-1340523	00000	602379	183	01/01/2021	12/31/2021

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
17842	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

AMES-GRENZ INSURANCE SERVICES, INC.
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
17842	0		3

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(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. Specify nature of costs ▶	**6d**	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [X] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [X] 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**	904854
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

2021

This Form is Open to Public Inspection

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

A Name of plan
HANLEES DEALERSHIP GROUP HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
HANLEES DEALERSHIP GROUP

D Employer Identification Number (EIN)
26-1445589

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
DIRECT DENTAL ADMINISTRATORS, LLC

(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
94-3270798		S9013	258	01/01/2021	12/31/2021

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
4771	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

AMES-GRENZ INSURANCE SERVICES, INC.
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
4771	0		3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [X] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [X] 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**	14319
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

2021

This Form is Open to Public Inspection

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

A Name of plan
HANLEES DEALERSHIP GROUP HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
HANLEES DEALERSHIP GROUP

D Employer Identification Number (EIN)
26-1445589

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

1 Coverage Information:

(a) Name of insurance carrier
UNITED OF OMAHA LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
47-0322111	69868	G000BSCW	331	01/01/2021	12/31/2021

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
4163	2064

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

AMES-GRENZ INSURANCE SERVICES, INC.
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4163	2064	ADMINISTRATION	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. Specify nature of costs ▶	**6d**	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [X] Other (specify) ▶ ACCIDENTAL DEATH AND DISMEMBERMENT AND VOLUNTARY LIFE AND 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**	41624
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

2021

This Form is Open to Public Inspection

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

A Name of plan
HANLEES DEALERSHIP GROUP HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
HANLEES DEALERSHIP GROUP

D Employer Identification Number (EIN)
26-1445589

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	LT806 ET AL	31	01/01/2021	12/31/2021

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
11284	371

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

MARK HUBER
4161 LEISURE LN
PLACERVILLE, CA 95667

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
35	0		3

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

CHRIS KELLY
252 WIKIUP MEADOWS DR
SANTA ROSA, CA 95403

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
6	0		3

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

LAWLEN INSURANCE SOLUTIONS LLC
1901 66TH AVE
SACRAMENTO, CA 95822

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
54	0		3

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

DERREK LYN KECK
18080 DAMIAN WAY
SALINAS, CA 93907

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
5	0		3

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

SLR INSURANCE SOLUTIONS INC
179 PINE HAVEN DR
ST JOHNS, FL 32259

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
7	0		3

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

JAMES SPROUSE
13122 MESA CREST PL
SAN DIEGO, CA 92129

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
3	0		3

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

LISA HUTCHERSON
5690 LILYVIEW WAY
ELK GROVE, CA 95757

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
3	0		3

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

ROBERT PILKENTON
6643 FM 2187 RD
SEALY, TX 77474

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
4	0		3

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

TALLY RHOADES
32 SOLAR DR
PUEBLO, CO 81005

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
5	0		3

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

RYAN OLSON
1140 MANGROVE AVE STE D
CHICO, CA 95926

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
31	0		3

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

EDGEWOOD PARTNERS INSURANCE CENTER
P.O. BOX 734004
CHICAGO, IL 60673

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
71	0		3

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

AUSTIN RICE
205 PERSIMMON TRL
WOODSTOCK, CA 30188

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
96	0		3

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

LEE C GARLAND
1398 ALBERTON CIR
LINCOLN, CA 95648

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
107	0		3

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

DANNY J LEON
10550 BAYMEADOWS RD UNIT 429
JACKSONVILLE, FL 32256

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
15	0		3

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

DAVID B KITCHEN
1260 N DUTTON AVE STE 180
SANTA ROSA, CA 95401

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
4	0		3

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

AMY MARIE LUDWICK
316 BARBATO LN
SACRAMENTO, CA 95814

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
11	0		3

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

APRIL MARIE ROBERTS
3540 SPRINGFIELD DR
FAIRFIELD, CA 94534

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
22	0		3

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

DARRYL W VIDOR
3314 EUROPA ST
ROSEVILLE, CA 95661

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
28	0		3

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

NICHOLAS E VIGIL
7808 E CYPRESS ST
SCOTTSDALE, AZ 85257

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
5	0		3

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

ASSUREDPARTNERS OF CA INS SERV LLC
1455 RESPONSE RD STE 260
SACRAMENTO, CA 95815

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
46	0		3

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

LES HEINSEN INS SERVICES INC
4416 VIA PALAGIO
FAIR OAKS, CA 95628

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
55	0		3

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

MICHAEL JAMES RHODD
4160 GREEN VALLEY RD
FAIRFIELD, CA 94534

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
51	0		3

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

PETER JAMES SARANTIS
7775 DUTRA BEND DR
SACRAMENTO, CA 95831

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
209	0		3

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

LARS J RONTEN
3178 SOFIA DR
LINCOLN, CA 95648

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
222	0		3

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

JAMES SARANTIS
14132 SE FIRCREST CT
PORTLAND, OR 97236

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
329	53		3

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

JACE G KUERSTEN
1574 SAN FERNANDO DR
CORONA, CA 92882

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
646	50		3

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

RONDA MATHEW
2030 13TH STREET APT 3
SACRAMENTO, CA 95818

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
592	0		3

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

ANDY B GLENN II
2999 DOUGLAS BLVD STE 180
ROSEVILLE, CA 95661

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
638	3		3

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

MARCI MARIE OTIS
200 JULINA LN
ROSEBURG, OR 97471

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
239	0		3

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

AMES-GRENZ INSURANCE SERVICES, INC.
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2640	0		3

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

CELITA ANN PEDRO
6705 MIRAVISTA DR
ROCKLIN, CA 95677

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
5086	264		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	

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. Specify nature of costs ▶	**6d**	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [X] Temporary disability (accident and sickness)
- **f** [ ] 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) ▶ HOSPITAL & CANCER

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**	28209
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)

A Name of plan: **DKD OF DAVIS INC**

PART 1 **Information Concerning Insurance Contract, Fees, and Commissions**

1. Coverage

(a) Name of insurance carrier: **WESTERN HEALTH ADVANTAGE**

(b) EIN: **68-0393304**

(d) Contract or identification number: **108294**

(e) Approximate number of persons covered at end of policy or contract year: **240**

Policy or contract year: **(f) From** **01/01/2021** **(g) To** **12/31/2021**

2. Insurance fees and commissions paid to agents, brokers and other persons

TOTAL AMOUNT OF COMMISSIONS PAID: $42,674.61

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

AMES GRENZ INSURANCE SERVICES
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864-5743

(b) Amount of commissions paid: **$42,674.61**

1. Premiums paid to carrier: **$853,491.34**

2. HMO Contract: Yes

KAISER PERMANENTE®

Attention: 5500 Central Team
3840 Murphy Canyon Road
San Diego, CA 92123

HILLTOP TOYOTA, INC.
BARBARA MARTINEZ
4640 W AMERICA DR
FAIRFIELD, CA 94534-4186

Reporting Period: 01/2021 - 12/2021

March 8, 2022

Dear HILLTOP TOYOTA, INC.:

Enclosed is your information from Kaiser Foundation Health Plan Inc that may assist you in completing the Schedule A to the Form 5500. The enclosed report provides you with the following information:

- Kaiser Foundation Health Plan Inc Employer Identification Number (EIN) and National Association of Insurance Commissioners (NAIC) code.
- The name and address of your broker, or other agent working on your behalf, who received compensation from Kaiser Foundation Health Plan Inc during your plan's contract year.
- The amount of sales and base commissions paid to your broker, or other agent working on your behalf, during your plan's contract year.
- The amount of any fees paid to your broker, or other agent working on your behalf during your plan's contract year. (Please note that bonus payments and non-monetary compensation are defined as fees on the actual Schedule A to the Form 5500.)
- The approximate number of covered persons as of the last day of your contract year. (The approximate number of covered persons includes the number of health plan subscribers in addition to their spouses and dependents, if any.)
- The total amount of premiums received by Kaiser Foundation Health Plan Inc during your plan's contract year.

Please be aware that the amount of premium dollars provided on the enclosed report is based on the date Kaiser Foundation Health Plan Inc processed your premium payment. The enclosed premium information is not based on coverage or billing periods.

Kaiser Foundation Health Plan Inc is providing the enclosed information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completion of Schedule A to the Form 5500. If you feel you have received this information in error and do not file the Form 5500, please contact your Kaiser Permanente representative to request to have this report discontinued in future years. If you are unsure about your requirement to file the Form 5500 you should contact your broker, tax advisor, legal counsel or other qualified advisor for guidance. Kaiser Permanente is unable to help determine if you are required to file the Form 5500.

We at Kaiser Foundation Health Plan Inc value our business relationship with you and trust that you share our philosophy of maintaining the highest ethical standards of business practices. Our practices for broker compensation disclosure reporting reflect our shared commitment to full compliance with the law. Thank you for your continued support.

Sincerely,
Kaiser Foundation Health Plan Inc
5500-Central-Team@kp.org

This page is intentionally left blank.

KAISER PERMANENTE®

INSURANCE INFORMATION

Insurance companies are required to provide the following information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completing the Schedule A of your Form 5500.

Part I: Information Concerning Insurance Coverage, Fees, and Commissions

Name of Insurance Carrier: Kaiser Foundation Health Plan Inc
Plan Sponsor's Name: HILLTOP TOYOTA, INC.

Information Concerning Insurance Contract Coverage

Kaiser Foundation Health Plan Region: CA
Insurance Carrier: Kaiser Foundation Health Plan Inc
Insurance Carrier Employer Identification Number: 94-1340523
Insurance Carrier NAIC Code: 00000
Plan Sponsor Contract or Identification Number: 602379
Approximate number of persons covered at end of policy contract year: 183
Contract Year from 01/2021 - 12/2021

Information Concerning Insurance Contract Fees and Commissions

Total Amount of Commissions Paid: $17,842.33
Total Amount of Fees Paid: $0.00

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

Ames-Grenz Insurance Services, Inc.
3435 AMERICAN RIVER DR STE C
SACRAMENTO, CA 95864-5797

Amount of sales and base commissions paid to Ames-Grenz Insurance Services, Inc.: $17,842.33
Fees and other compensation paid to Ames-Grenz Insurance Services, Inc.: $0.00
Bonus Amount: $0.00
Bonus Purpose:
Value of Non-Monetary Compensation: $0.00
Type/Purpose of Non-Monetary Compensation:

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

None

Amount of sales and base commissions paid to None $0.00
Fees and other compensation paid to None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation: $0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None $0.00
Fees and other compensation paid to None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation: $0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None $0.00
Fees and other compensation paid to None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation: $0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None $0.00
Fees and other compensation paid to None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation: $0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None $0.00
Fees and other compensation paid to None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation: $0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None $0.00
Fees and other compensation paid to None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation: $0.00
Type/Purpose of Non-Monetary Compensation: None

Part II: Investment and Annuity Contract Information

Kaiser Foundation Health Plan Inc is not offering you an investment or annuity contract.

Part III: Welfare Benefit Contract Information

Premium received by Kaiser Foundation Health Plan Inc during your plan's contract year: $904,854.23

Part IV: Provision of Information

Kaiser Foundation Health Plan, Inc. hereby certifies that the foregoing statement furnished pursuant to 29 US Code of Federal Regulations 2520.103(c) is complete and accurate.



Laura Sokolowski
Vice President, Commercial Membership Administration
Kaiser Foundation Health Plan, Inc
March 8, 2022

This page is intentionally left blank.

Form 5500 Information for Hanlees Automotive Group – DENTAL PLAN

Their information is:

Hanlees Automotive-Self Funded Dental Plan
Plan Number: S9013

Plan Year: 1/1/2021 through 12/31/2021

Our information is:

Direct Dental Administrators, LLC
7510 Shoreline Drive
Stockton, CA 95219
844-213-8140
Contract Administrators EIN: 94-3270798

Plan information is:

Number of participants on January 1, 2021: 274
There was 4 COBRA participant.
Total number of participants on December 31, 2021: 258

Administrative Fees paid to Contract Administrator 1/1/2021 through 12/31/2021: $14,319.00
Commission Paid: $4,771.50

Plan Funding and Benefit Arrangement: General Assets of the Sponsor

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

February 10, 2022

DKD OF DAVIS INC
4640 W AMERICA DR
FAIRFIELD, CA 94534

Re: Certified Information for Department of Labor
Form 5500, Schedule A – Group Number(s):
GLUG0BSCW GVTL0BSCW

Thank you for choosing Mutual of Omaha as your group insurance carrier. We appreciate the opportunity to service you and your employees. Attached, you'll find the Form 5500, Schedule A.

I certify that the attached information for the Form 5500, Schedule A, Part I and Part III, has been taken from our company records and is correct to the best of my knowledge. Mutual of Omaha is providing you with the attached information but makes no representation regarding reporting requirements. Please consult your attorney or other advisor as to your reporting obligations.

For questions, please contact your dedicated Customer Service team or call 1-800-655-5142.

Sincerely,

James Davenport
Senior Vice President
Finance Operations

This Page Intentionally Left Blank

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

DKD OF DAVIS INC
FAIRFIELD, CA

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000BSCW
Data for Period: 01-01-2021 to 01-01-2022
Legacy Group ID: GLUG0BSCW
Type of Contract: NON-RETENTION

Benefits Provided	Persons Covered
Life & AD&D	331

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
AMES-GRENZ INSURANCE SERV INC 3435 AMERICAN RIVER DR STE 3435 SACRAMENTO, CA 95864	523		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 5,229

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

Group Office: SAN FRANCISCO

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

DKD OF DAVIS INC
FAIRFIELD, CA

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000BSCW **Data for Period:** 01-01-2021 to 01-01-2022
Legacy Group ID: GVTL0BSCW
Type of Contract: NON-RETENTION

Benefits Provided	Persons Covered
Life & AD&D Voluntary	135

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
AMES-GRENZ INSURANCE SERV INC 3435 AMERICAN RIVER DR STE 3435 SACRAMENTO, CA 95864	0	2,064	Administration	5
AMES-GRENZ INSURANCE SERV INC 3435 AMERICAN RIVER DR STE 3435 SACRAMENTO, CA 95864	3,640		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 36,395

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

Group Office: SAN FRANCISCO

***Amounts provided under the "Commissions Paid" column include all earned 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, prizes, bonuses or other forms of non-monetary compensation paid relative to your account. These amounts are calculated based on a calendar year. Some bonuses, fees, and contests are paid based on the aggregate amount of sales for all accounts throughout the calendar year. To determine the value of these items relative 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
GDT72	$2,072.07	3

Group Address	Name of Insurance Carrier
HANLEES HILLTOP NISSAN	AFLAC
ATTN LULU CLIFFORD	1932 WYNNTON ROAD
3277 AUTO PLZ	COLUMBUS, GA 31999
RICHMOND, CA 00009-4806	**PLAN YEAR 1/1/2021 to 12/31/2021**

CONTRACT NUMBER	NAIC CODE
82-2723296	60380

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
CELITA ANN PEDRO 6705 MIRAVISTA DR ROCKLIN, CA 95677	$126.83	$0.00
- AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR STE C SACRAMENTO, CA 95864	$26.29	$0.00
JACE G KUERSTEN 1574 SAN FERNANDO DR CORONA, CA 92882	$23.10	$0.00
JAMES S SARANTIS 14132 SE FIRCREST CT PORTLAND, OR 97236	$20.90	$0.00

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
- ASSUREDPARTNERS OF CA INS SERV LLC 1455 RESPONSE RD STE 260 SACRAMENTO, CA 95815	$13.09	$0.00
DARRYL W VIDOR 3314 EUROPA ST ROSEVILLE, CA 95661	$8.14	$0.00
- LES HEINSEN INS SERVICES INC 4416 VIA PALAGIO FAIR OAKS, CA 95628	$6.71	$0.00
PETER JAMES SARANTIS 7775 DUTRA BEND DR SACRAMENTO, CA 95831	$6.71	$0.00
APRIL MARIE ROBERTS 3540 SPRINGFIELD DR FAIRFIELD, CA 94534	$6.16	$0.00
AMY MARIE LUDWICK 316 BARBATO LN SACRAMENTO, CA 95814	$1.98	$0.00
MICHAEL JAMES RHODD 4160 GREEN VALLEY RD FAIRFIELD, CA 94534	$1.10	$0.00
Sum:	$241.01	$0.00

***Amounts provided under the "Commissions Paid" column include all earned 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, prizes, bonuses or other forms of non-monetary compensation paid relative to your account. These amounts are calculated based on a calendar year. Some bonuses, fees, and contests are paid based on the aggregate amount of sales for all accounts throughout the calendar year. To determine the value of these items relative 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
GDU12	$2,449.37	4

Group Address	Name of Insurance Carrier
HANLEES HILLTOP HYUNDAI	AFLAC
ATTN LULU CLIFFORD	1932 WYNNTON ROAD
3285 AUTO PLZ	COLUMBUS, GA 31999
RICHMOND, CA 00009-4806	**PLAN YEAR 1/1/2021 to 12/31/2021**

CONTRACT NUMBER	NAIC CODE
82-2723296	60380

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
CELITA ANN PEDRO 6705 MIRAVISTA DR ROCKLIN, CA 95677	$112.64	$0.00
- AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR STE C SACRAMENTO, CA 95864	$62.15	$0.00
JACE G KUERSTEN 1574 SAN FERNANDO DR CORONA, CA 92882	$56.54	$0.00
PETER JAMES SARANTIS 7775 DUTRA BEND DR SACRAMENTO, CA 95831	$27.83	$0.00
JAMES S SARANTIS 14132 SE FIRCREST CT PORTLAND, OR 97236	$17.71	$0.00

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
Sum:	$276.87	$0.00

***Amounts provided under the "Commissions Paid" column include all earned 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, prizes, bonuses or other forms of non-monetary compensation paid relative to your account. These amounts are calculated based on a calendar year. Some bonuses, fees, and contests are paid based on the aggregate amount of sales for all accounts throughout the calendar year. To determine the value of these items relative 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
LY399	$16,768.09	20

Group Address	Name of Insurance Carrier
HANLEES HILLTOP TOYOTA	AFLAC
ATTN SHELLY FOSTER	1932 WYNNTON ROAD
3255 AUTO PLZ	COLUMBUS, GA 31999
RICHMOND, CA 00009-4806	**PLAN YEAR 1/1/2021 to 12/31/2021**

CONTRACT NUMBER	NAIC CODE
82-2723296	60380

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
CELITA ANN PEDRO 6705 MIRAVISTA DR ROCKLIN, CA 95677	$1,521.75	$60.82
- AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR STE C SACRAMENTO, CA 95864	$794.35	$0.00
MARCI MARIE OTIS 200 JULINA LN ROSEBURG, OR 97471	$205.37	$0.00
ANDY B GLENN II 2999 DOUGLAS BLVD SUIE 180 ROSEVILLE, CA 95661	$203.51	$0.00

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
RONDA MATHEW 2030 13TH ST APT 3 SACRAMENTO, CA 95818	$166.00	$0.00
JACE G KUERSTEN 1574 SAN FERNANDO DR CORONA, CA 92882	$162.77	$12.16
JAMES S SARANTIS 14132 SE FIRCREST CT PORTLAND, OR 97236	$120.56	$12.16
LARS J RONTEN 3178 SOFIA DR LINCOLN, CA 95648	$71.94	$0.00
PETER JAMES SARANTIS 7775 DUTRA BEND DR SACRAMENTO, CA 95831	$39.99	$0.00
MICHAEL JAMES RHODD 4160 GREEN VALLEY RD FAIRFIELD, CA 94534	$37.97	$0.00
- LES HEINSEN INS SERVICES INC 4416 VIA PALAGIO FAIR OAKS, CA 95628	$21.03	$0.00
- ASSUREDPARTNERS OF CA INS SERV LLC 1455 RESPONSE RD STE 260 SACRAMENTO, CA 95815	$4.73	$0.00
NICHOLAS E VIGIL 7808 E CYPRESS ST SCOTTSDALE, AZ 85257	$4.40	$0.00
DARRYL W VIDOR 3314 EUROPA ST ROSEVILLE, CA 95661	$2.97	$0.00
APRIL MARIE ROBERTS 3540 SPRINGFIELD DR FAIRFIELD, CA 94534	$2.53	$0.00
AMY MARIE LUDWICK 316 BARBATO LN SACRAMENTO, CA 95814	$2.22	$0.00
DAVID B KITCHEN 1260 N DUTTON AVE STE 180 SANTA ROSA, CA 95401	$1.15	$0.00
DAVID B KITCHEN 5230 HARTER LN LA CANADA FLINTRIDGE, CA 91011	$0.12	$0.00
Sum:	$3,363.36	$85.14

***Amounts provided under the "Commissions Paid" column include all earned 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, prizes, bonuses or other forms of non-monetary compensation paid relative to your account. These amounts are calculated based on a calendar year. Some bonuses, fees, and contests are paid based on the aggregate amount of sales for all accounts throughout the calendar year. To determine the value of these items relative 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
Y3099	$5,448.08	9

Group Address	Name of Insurance Carrier
HANLEES NAPA INC	AFLAC
ATTN: HR DEPT	1932 WYNNTON ROAD
495 SOSCOL AVE	COLUMBUS, GA 31999
NAPA, CA 00009-4559	**PLAN YEAR 1/1/2021 to 12/31/2021**

CONTRACT NUMBER	NAIC CODE
82-2723296	60380

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
CELITA ANN PEDRO 6705 MIRAVISTA DR ROCKLIN, CA 95677	$487.80	$27.57
- AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR STE C SACRAMENTO, CA 95864	$283.28	$0.00
JACE G KUERSTEN 1574 SAN FERNANDO DR CORONA, CA 92882	$76.23	$5.52
RONDA MATHEW 2030 13TH ST APT 3 SACRAMENTO, CA 95818	$70.47	$0.00

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
ANDY B GLENN II 2999 DOUGLAS BLVD SUIE 180 ROSEVILLE, CA 95661	$66.34	$0.00
LARS J RONTEN 3178 SOFIA DR LINCOLN, CA 95648	$36.30	$0.00
PETER JAMES SARANTIS 7775 DUTRA BEND DR SACRAMENTO, CA 95831	$26.18	$0.00
- LAWLEN INSURANCE SOLUTIONS LLC 1901 66TH AVE SACRAMENTO, CA 95822	$19.03	$0.00
JAMES S SARANTIS 14132 SE FIRCREST CT PORTLAND, OR 97236	$12.98	$5.52
CHRIS KELLY 252 WIKIUP MEADOWS DR SANTA ROSA, CA 95403	$6.38	$0.00
MARK C HUBER 4164 LEISURE LN PLACERVILLE, CA 95667	$5.72	$0.00
DAVID B KITCHEN 1260 N DUTTON AVE STE 180 SANTA ROSA, CA 95401	$2.40	$0.00
DAVID B KITCHEN 5230 HARTER LN LA CANADA FLINTRIDGE, CA 91011	$0.24	$0.00
Sum:	$1,093.35	$38.61

***Amounts provided under the "Commissions Paid" column include all earned 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, prizes, bonuses or other forms of non-monetary compensation paid relative to your account. These amounts are calculated based on a calendar year. Some bonuses, fees, and contests are paid based on the aggregate amount of sales for all accounts throughout the calendar year. To determine the value of these items relative 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
G2Q31	$1,471.58	3

Group Address	Name of Insurance Carrier
HANLEES FREMONT INC	AFLAC
ATTN MS LULU CLIFFORD	1932 WYNNTON ROAD
4640 W AMERICA DR	COLUMBUS, GA 31999
FAIRFIELD, CA 00009-4534	**PLAN YEAR 1/1/2021 to 12/31/2021**

CONTRACT NUMBER	NAIC CODE
82-2723296	60380

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
CELITA ANN PEDRO 6705 MIRAVISTA DR ROCKLIN, CA 95677	$55.66	$0.00
- AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR STE C SACRAMENTO, CA 95864	$38.28	$0.00
JACE G KUERSTEN 1574 SAN FERNANDO DR CORONA, CA 92882	$33.33	$0.00
PETER JAMES SARANTIS 7775 DUTRA BEND DR SACRAMENTO, CA 95831	$15.84	$0.00
DANNY J LEON 10550 BAYMEADOWS RD UNIT 429 JACKSONVILLE, FL 32256	$15.18	$0.00

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
- SLR INSURANCE SOLUTIONS INC 179 PINE HAVEN DR ST JOHNS, FL 32259	$7.48	$0.00
JAMES S SARANTIS 14132 SE FIRCREST CT PORTLAND, OR 97236	$5.06	$0.00
DERREK LYN KECK 18080 DAMIAN WAY SALINAS, CA 93907	$4.84	$0.00
Sum:	$175.67	$0.00

***Amounts provided under the "Commissions Paid" column include all earned 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, prizes, bonuses or other forms of non-monetary compensation paid relative to your account. These amounts are calculated based on a calendar year. Some bonuses, fees, and contests are paid based on the aggregate amount of sales for all accounts throughout the calendar year. To determine the value of these items relative 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
LT806	$30,939.52	31

Group Address	Name of Insurance Carrier
HANLEES CHEVROLET	AFLAC
ATTN HR DEPT	1932 WYNNTON ROAD
4989 CHILES RD	COLUMBUS, GA 31999
DAVIS, CA 00009-5618	**PLAN YEAR 01/01/2021 to 12/31/2021**

CONTRACT NUMBER	NAIC CODE
82-2723296	60380

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
CELITA ANN PEDRO 6705 MIRAVISTA DR ROCKLIN, CA 95677	$2,781.80	$176.07
- AMES GRENZ INS SVCS INC 3435 AMERICAN RIVER DR STE C SACRAMENTO, CA 95864	$1,435.74	$0.00
ANDY B GLENN II 2999 DOUGLAS BLVD SUIE 180 ROSEVILLE, CA 95661	$368.27	$3.46
RONDA MATHEW 2030 13TH ST APT 3 SACRAMENTO, CA 95818	$355.71	$0.00

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
JACE G KUERSTEN 1574 SAN FERNANDO DR CORONA, CA 92882	$293.86	$32.24
JAMES S SARANTIS 14132 SE FIRCREST CT PORTLAND, OR 97236	$151.41	$35.70
LARS J RONTEN 3178 SOFIA DR LINCOLN, CA 95648	$113.79	$0.00
LEE C GARLAND 1398 ALBERTON CIR LINCOLN, CA 95648	$107.14	$0.00
AUSTIN J RICE 205 PERSIMMON TRL WOODSTOCK, GA 30188	$95.81	$0.00
PETER JAMES SARANTIS 7775 DUTRA BEND DR SACRAMENTO, CA 95831	$92.88	$0.00
- EDGEWOOD PARTNERS INSURANCE CENTER PO BOX 734004 CHICAGO, IL 60673	$71.17	$0.00
- LAWLEN INSURANCE SOLUTIONS LLC 1901 66TH AVE SACRAMENTO, CA 95822	$34.76	$0.00
MARCI MARIE OTIS 200 JULINA LN ROSEBURG, OR 97471	$33.55	$0.00
RYAN T OLSON 1140 MANGROVE AVE STE D CHICO, CA 95926	$31.02	$0.00
MARK C HUBER 4164 LEISURE LN PLACERVILLE, CA 95667	$29.11	$0.00
- ASSUREDPARTNERS OF CA INS SERV LLC 1455 RESPONSE RD STE 260 SACRAMENTO, CA 95815	$27.72	$0.00
- LES HEINSEN INS SERVICES INC 4416 VIA PALAGIO FAIR OAKS, CA 95628	$27.10	$0.00
DARRYL W VIDOR 3314 EUROPA ST ROSEVILLE, CA 95661	$17.24	$0.00
ROBERT D WILKINS 2685 BAYBERRY DR FRUITLAND, ID 83619	$17.05	$0.00
APRIL MARIE ROBERTS 3540 SPRINGFIELD DR FAIRFIELD, CA 94534	$13.73	$0.00

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
MICHAEL JAMES RHODD 4160 GREEN VALLEY RD FAIRFIELD, CA 94534	$11.70	$0.00
AMY MARIE LUDWICK 316 BARBATO LN SACRAMENTO, CA 95814	$6.64	$0.00
TALLY L RHOADES 32 SOLAR DR PUEBLO, CO 81005	$4.85	$0.00
ROBERT L PILKENTON 6643 FM 2187 RD SEALY, TX 77474	$3.96	$0.00
LISA M HUTCHERSON 5690 LILYVIEW WAY ELK GROVE, CA 95757	$3.06	$0.00
JAMES DONALD SPROUSE 13122 MESA CREST PL SAN DIEGO, CA 92129	$2.86	$0.00
NICHOLAS E VIGIL 7808 E CYPRESS ST SCOTTSDALE, AZ 85257	$0.66	$0.00
KELLY E TIMS 866 REDWOOD BLVD REDDING, CA 96003	$0.44	$0.00
WILLIAM A WEST PO BOX 765 PALO CEDRO, CA 96073	$0.44	$0.00
Sum:	$6,133.47	$247.47