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 02/01/2020 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.)
- [X] a single-employer plan
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [X] 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
- [X] the DFVC program
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
ABRASIVE-FORM LLC EMPLOYEE BENEFITS PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 02/01/2008

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)
ABRASIVE-FORM LLC

454 SCOTT DRIVE
BLOOMINGDALE, IL 60108

2b Employer Identification Number (EIN) 47-5282271

2c Plan Sponsor's telephone number 630-893-7800

2d Business code (see instructions) 332110

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.	10/05/2022	JOHN HANSSLER
	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**	172
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)**	172
a(2) Total number of active participants at the end of the plan year	**6a(2)**	234
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	0
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	234
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**	0

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 4L

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☒ No

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

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

11c Enter the Receipt Confirmation Code for the 2020 Form M-1 annual report. If the plan was not required to file the 2020 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2020

This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 02/01/2020 and ending 12/31/2020

A Name of plan
ABRASIVE-FORM LLC EMPLOYEE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
ABRASIVE-FORM LLC

D Employer Identification Number (EIN)
47-5282271

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
STANDARD 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
93-0242990	69019	162839	234	02/01/2020	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
13324	1377

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

KIBBLE AND PRENTICE HOLDING COMPANY
PO BOX 62949
VIRGINIA BEACH, VA 23466

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
13299	1377	CONTINGENT COMPENSATION	3

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

BROWN AND BROWN OF FLORIDA, INC.
2290 LUCIEN WAY, SUITE 400
MAITLAND, FL 32751

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
25	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	

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [X] Dental
- **c** [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) ▶ ACCIDENTAL DEATH AND DISMEMBERMENT

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	200419		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	1111		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	201530
b Benefit charges (1) Claims paid	**9b(1)**	229528		
(2) Increase (decrease) in claim reserves	**9b(2)**	288270		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	517798
(4) Claims charged			**9b(4)**	517798
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	14701		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**	500		
(D) Other expenses	**9c(1)(D)**	46779		
(E) Taxes	**9c(1)(E)**	840		
(F) Charges for risks or other contingencies	**9c(1)(F)**	9327		
(G) Other retention charges	**9c(1)(G)**	9116		
(H) Total retention			**9c(1)(H)**	81263
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	0
(2) Claim reserves			**9d(2)**	769454
(3) Other reserves			**9d(3)**	0
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	0
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
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. ▶

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Authorization to Electronically Sign and File Health and Welfare Form 5500

I hereby authorize any employee of Wrangle, a division of Ascensus, LLC ("Service Provider") to electronically sign and transmit Health and Welfare (H&W) Form 5500s on my behalf through EFAST 2.

I further understand the following in granting authority:

I, the Plan Administrator/Plan Sponsor and signer, have the final responsibility for the H&W Form 5500, and therefore, I must review the filing carefully before I sign and agree to have it transmitted.

I must provide to Wrangle a signed and dated copy of the Form 5500. These signed copies are required per Department of Labor (DOL) rules and will be attached to the H&W Form 5500 when transmitted.

Wrangle is not liable for and does not have a duty to indemnify or hold the Plan Administrator/Plan Sponsor harmless from any penalties, damages, incidental charges or consequential damages imposed or caused as a result of the transmission of the H&W Form 5500 on my behalf. Wrangle, LLC is merely providing an option to me that will make the filing process easier should I elect this option. Wrangle, LLC or its employees shall not be deemed an administrator or other fiduciary with respect to any plan. I understand that I do have the option to obtain signing credentials and to directly submit the H&W Form 5500 to the DOL electronically.

I must sign and keep a paper copy of the completed H&W Form 5500 in my files, per ERISA.

I acknowledge that the signature as submitted through DocuSign is my adopted signature, and that I have reviewed and signed the Form 5500 as myself. Further, I accept this as my legal and binding signature.

By the signature below, I am acknowledging that I am the person responsible for the H&W Form 5500 for the entity listed below and am authorizing Wrangle to submit all Health and Welfare Form 5500s for the Form Year(s) checked below.

I may revoke or change authorization at any time by written notification to the Service Provider.

Company/Entity Name: ABRASIVE-FORM LLC

Plan Administrator Name: John Hanssler

Please print your name clearly, or type in from your computer. Thank you!

Plan Administrator Signature: DocuSigned by: John Hanssler 56A1099589F1415...

Date: 10/5/2022

Note: A copy of this authorization must be kept in your records.

Failure to follow these instructions and complete this form in its entirety, including signature, will delay transmission of the 5500.

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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

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Part I Annual Report Identification Information

For calendar plan year 2020 or fiscal plan year beginning 02/01/2020 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.)
- [X] a single-employer plan
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [X] 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
- [X] the DFVC program
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
ABRASIVE-FORM LLC EMPLOYEE BENEFITS PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 02/01/2008

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)
ABRASIVE-FORM LLC

454 SCOTT DRIVE
BLOOMINGDALE, IL 60108

2b Employer Identification Number (EIN) 47-5282271

2c Plan Sponsor's telephone number 630-893-7800

2d Business code (see instructions) 332110

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	DocuSigned by: John Hanssler 5EA0F0B8F1A4D8...	10/5/2022	John Hanssler
	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

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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**	172
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)**	172
a(2) Total number of active participants at the end of the plan year	**6a(2)**	234
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	0
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	234
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 4L

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

(1)	[X]	Insurance
(2)	[ ]	Code section 412(e)(3) insurance contracts
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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] 1 **A** (Insurance Information)
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

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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_____

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SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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▶ **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 02/01/2020 and ending 12/31/2020

A Name of plan
ABRASIVE-FORM LLC EMPLOYEE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
ABRASIVE-FORM LLC

D Employer Identification Number (EIN)
47-5282271

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
STANDARD 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
93-0242990	69019	162839	234	02/01/2020	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
13324	1377

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
KIBBLE AND PRENTICE HOLDING COMPANY
PO BOX 62949
VIRGINIA BEACH, VA 23466

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
13299	1377	CONTINGENT COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
BROWN AND BROWN OF FLORIDA, INC.
2290 LUCIEN WAY, SUITE 400
MAITLAND, FL 32751

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
25			3

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(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	

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Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

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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) ▶ ACCIDENTAL DEATH AND DISMEMBERMENT

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	200419		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	1111		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	201530
b Benefit charges (1) Claims paid	**9b(1)**	229528		
(2) Increase (decrease) in claim reserves	**9b(2)**	288270		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	517798
(4) Claims charged			**9b(4)**	517798
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	14701		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**	500		
(D) Other expenses	**9c(1)(D)**	46779		
(E) Taxes	**9c(1)(E)**	840		
(F) Charges for risks or other contingencies	**9c(1)(F)**	9327		
(G) Other retention charges	**9c(1)(G)**	9116		
(H) Total retention			**9c(1)(H)**	81263
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	0
(2) Claim reserves			**9d(2)**	769454
(3) Other reserves			**9d(3)**	0
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	0
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
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. ▶

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Carriers' Schedules

DS

I have reviewed the Carrier Schedules.

The following document(s) are the Schedules from the Carrier(s) of the Plan Sponsor's ERISA Plan.

These documents represent a snap shot taken on the last day of the policy period per the Carriers' systems. The data was copied and placed into the Plan Sponsor's 5500 report.

Please note: If the data was altered in any way, the liability of the data will no longer rest on the Carrier; instead, it would rest upon the Plan Sponsor/Plan Administrator.

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aetna®

INSURANCE INFORMATION

AETNA LIFE INSURANCE COMPANY AND AFFILIATES

The following information is intended for your use in completing Schedule A of Form 5500.

For Fiscal Plan Year beginning 2/1/2020, and ending 12/31/2020.

C. Name of Plan Sponsor: ABRASIVE-FORM, LLC

PART I Information Concerning Insurance Contract Coverage, Fees, and Commissions.

1. Coverage: Traditional Prospective

(a) Name of Insurance Carrier: Aetna Life Insurance Co.	(d) Contract Number or Identification:	(e) Approximate number of persons covered at end of policy or contract year.	Policy or contract year	
(b) EIN 06-6033492	0450354-SL	139	(f) From: 2/1/2020	(g) To: 12/31/2020
(c) NAIC Code: See Attached Listing				

2. Insurance fees and commissions paid to agents and brokers:

Contract or identification	(a) Name and address of the agents or brokers to whom commissions or fees were paid.	(b) Amount of commissions paid	(c) & (d) Fees Paid	
			Amount	Purpose
0450354-SL	KIBBLE & PRENTICE HOLDING COMPANY DBA USI NORTHWEST 601UNION ST SEATTLE WA 98101	$51,205.48		
TOTAL		$51,205.48		

Reported fees and commissions may be attributed to multiple Aetna companies.

Part III Welfare Benefit Contract Information

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

7 Benefit and contract type (check all applicable boxes)

- ☐ Health (other than dental or vision)
- ☐ Dental
- ☐ Vision
- ☐ Life Insurance
- ☐ Temporary disability (accident and sickness)
- ☐ Long-term disability
- ☐ Supplemental unemployment
- ☐ Prescription drug
- ☑ Stop loss (large deductible)
- ☐ HMO contract
- ☐ PPO contract
- ☐ Indemnity contract
- ☐ Accidental Death Dismemberment
- ☐ Short Term Disability

8 Experience Rated Contracts: N/A

9. Non experience rated contracts:

(a) Total premiums or subscription charges paid to carrier. $377,746.32

(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 2 above, report amount. . . . . .

Specify nature of costs -->

This information was generated as of July 01, 2022.

Date **July 01, 2022 FINAL RELEASE**

Registrar

AETNA LIFE INSURANCE COMPANY AND AFFILIATES hereby certifies that the foregoing statement is complete and accurate

0450354-SL-TP-07012022

This is a self-funded benefit and does not get reported on a Form 5500 schedule A. We did include the appropriate benefit code and checked general assets.

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State	NAIC Code	Service Area	EIN
	95094	Aetna Health Inc. (a Georgia Corporation)	06-6033492
	95910	Aetna Dental Inc (a Texas Corporation)	06-6033492
	60054	Aetna Life Insurance Company	06-6033492
	N/A	Aetna Dental of California Inc.	06-6033492
	11183	Aetna Dental Inc (a New Jersey Corporation)	06-6033492
	95003	Aetna Health Inc. (an Arizona Corporation)	06-6033492

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Long Form Information

The financial data below is provided for your information.
It can be used to complete the schedule a for the form 5500,
if your plan is required to file such a schedule.

c) Plan Sponsor: ABRASIVE FORM LLC

Part I
1) Coverage: - B) DENTAL

a) Carrier: Standard Insurance Company
b) EIN: 93-0242990
c) NAIC code: 000-69019
D) Contract number: 162839
E) Number of persons covered: 174
F) From: 02/01/2020
G) To: 12/31/2020

2) Insurance fees and commissions paid to agents, brokers, and other persons:
Amount of commissions paid: $5,266.77
Fees paid / amount: $0.00

a) Name & address of agent or broker to whom commission or fees were paid	b) Amount of Commission paid	Fees paid c) Amount	d) Purpose	e) Organization Code
KIBBLE & PRENTICE HOLDING CO PO BOX 62949 VIRGINIA BEACH, VA 23466	$4,718.38	$0.00	N/A	3
KIBBLE & PRENTICE HOLDING CO ATTN: USI NORTHWEST PO BOX 62949 VIRGINIA BEACH, VA 23466	$548.39*	$0.00	N/A	3

Total commissions paid: $4,718.38

Total contingent compensation paid: $548.39*

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Long Form Information

Part III - 162839
7) Benefit Type
B) DENTAL

8) Experience Rated Contracts

a) Premiums: (1) Amount Received	$104,850.16	
(2) Increase (decrease) in amount due but unpaid	$-1,324.00	
(3) Increase (decrease) in unearned premium reserve	$0.00	
(4) Earned ((1) + (2) - (3))		$103,527.00
b) Benefit charges (1) Claims paid	$86,080.29	
(2) Increase (decrease) in claim reserves	$701.00	
(3) Incurred claims (add(1) and (2))		$86,781.29
(4) Claims charged		$86,781.29
c) Remainder of premium: (1) Retention charges(on an accrual basis)		
(A) Commissions	$5,266.77	
(B) Administrative service or other fees	$0.00	
(C) Other specific acquisition costs	$0.00	
(D) Other expenses	$18,047.00	
(E) Taxes	$414.00	
(F) Charges for risks or other contingencies	$2,040.61	
(G) Other retention charges	$0.00	
(H) Total retention		$25,768.38
(2) Dividends or retroactive rate refunds		$0.00
d) Status of policyholder reserves at end of year:		
(1) Amount held to provide benefits after retirement		$0.00
(2) Claim reserves		$5,508.00
(3) Other reserves		$0.00
e) Dividends or retroactive rate refunds due		$0.00

Standard Insurance Company hereby certifies that this information is complete and accurate.

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Long Form Information

The financial data below is provided for your information.
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if your plan is required to file such a schedule.

c) Plan Sponsor: ABRASIVE FORM LLC

Part I
1) Coverage: - H) VISION

a) Carrier: Standard Insurance Company
b) EIN: 93-0242990
c) NAIC code: 000-69019
D) Contract number: 162839
E) Number of persons covered: 144
F) From: 02/01/2020
G) To: 12/31/2020

2) Insurance fees and commissions paid to agents, brokers, and other persons:
Amount of commissions paid: $1,905.31
Fees paid / amount: $0.00

a) Name & address of agent or broker to whom commission or fees were paid	b) Amount of Commission paid	Fees paid c) Amount	d) Purpose	e) Organization Code
KIBBLE & PRENTICE HOLDING CO PO BOX 62949 VIRGINIA BEACH, VA 23466	$1,816.74	$0.00	N/A	3
KIBBLE & PRENTICE HOLDING CO ATTN: USI NORTHWEST PO BOX 62949 VIRGINIA BEACH, VA 23466	$88.57*	$0.00	N/A	3

Total commissions paid: $1,816.74

Total contingent compensation paid: $88.57*

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Long Form Information

Part III - 162839
7) Benefit Type
H) VISION

8) Experience Rated Contracts

a) Premiums: (1) Amount Received	$18,167.52	
(2) Increase (decrease) in amount due but unpaid	$-181.00	
(3) Increase (decrease) in unearned premium reserve	$0.00	
(4) Earned ((1) + (2) - (3))		$17,986.00
b) Benefit charges (1) Claims paid	$8,343.49	
(2) Increase (decrease) in claim reserves	$210.00	
(3) Incurred claims (add(1) and (2))		$8,553.49
(4) Claims charged		$8,553.49
c) Remainder of premium: (1) Retention charges(on an accrual basis)		
(A) Commissions	$1,905.31	
(B) Administrative service or other fees	$0.00	
(C) Other specific acquisition costs	$0.00	
(D) Other expenses	$3,615.00	
(E) Taxes	$72.00	
(F) Charges for risks or other contingencies	$450.00	
(G) Other retention charges	$3,390.20	
(H) Total retention		$9,432.51
(2) Dividends or retroactive rate refunds		$0.00
d) Status of policyholder reserves at end of year:		
(1) Amount held to provide benefits after retirement		$0.00
(2) Claim reserves		$1,741.00
(3) Other reserves		$0.00
e) Dividends or retroactive rate refunds due		$0.00

Standard Insurance Company hereby certifies that this information is complete and accurate.

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Long Form Information

The financial data below is provided for your information.
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if your plan is required to file such a schedule.

c) Plan Sponsor: ABRASIVE FORM LLC

Part I
1) Coverage: - D) LIFE INSURANCE

a) Carrier: Standard Insurance Company
b) EIN: 93-0242990
c) NAIC code: 000-69019
D) Contract number: 162839
E) Number of persons covered: 234
F) From: 02/01/2020
G) To: 12/31/2020

2) Insurance fees and commissions paid to agents, brokers, and other persons:
Amount of commissions paid: $2,907.12
Fees paid / amount: $0.00

a) Name & address of agent or broker to whom commission or fees were paid	b) Amount of Commission paid	Fees paid c) Amount	d) Purpose	e) Organization Code
KIBBLE & PRENTICE HOLDING CO PO BOX 62949 VIRGINIA BEACH, VA 23466	$2,492.41	$0.00	N/A	3
BROWN & BROWN OF FLORIDA INC 2290 LUCIEN WAY STE 400 MAITLAND, FL 32751	$6.83	$0.00	N/A	3
KIBBLE & PRENTICE HOLDING CO ATTN: USI NORTHWEST PO BOX 62949 VIRGINIA BEACH, VA 23466	$407.88*	$0.00	N/A	3

Total commissions paid: $2,499.24

Total contingent compensation paid: $407.88*

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Long Form Information

Part III - 162839
7) Benefit Type
D) LIFE INSURANCE

8) Experience Rated Contracts

a) Premiums: (1) Amount Received	$39,559.88	
(2) Increase (decrease) in amount due but unpaid	$285.00	
(3) Increase (decrease) in unearned premium reserve	$0.00	
(4) Earned ((1) + (2) - (3))		$39,846.00
b) Benefit charges (1) Claims paid	$0.00	
(2) Increase (decrease) in claim reserves	$91,195.00	
(3) Incurred claims (add(1) and (2))		$91,195.00
(4) Claims charged		$91,195.00
c) Remainder of premium: (1) Retention charges(on an accrual basis)		
(A) Commissions	$2,907.12	
(B) Administrative service or other fees	$0.00	
(C) Other specific acquisition costs	$0.00	
(D) Other expenses	$4,982.00	
(E) Taxes	$193.00	
(F) Charges for risks or other contingencies	$2,780.12	
(G) Other retention charges	$0.00	
(H) Total retention		$10,862.24
(2) Dividends or retroactive rate refunds		$0.00
d) Status of policyholder reserves at end of year:		
(1) Amount held to provide benefits after retirement		$0.00
(2) Claim reserves		$98,467.00
(3) Other reserves		$0.00
e) Dividends or retroactive rate refunds due		$0.00

Standard Insurance Company hereby certifies that this information is complete and accurate.

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Long Form Information

The financial data below is provided for your information.
It can be used to complete the schedule a for the form 5500,
if your plan is required to file such a schedule.

c) Plan Sponsor: ABRASIVE FORM LLC

Part I
1) Coverage: - E) TEMPORARY DISABILITY

a) Carrier: Standard Insurance Company
b) EIN: 93-0242990
c) NAIC code: 000-69019
D) Contract number: 162839
E) Number of persons covered: 66
F) From: 02/01/2020
G) To: 12/31/2020

2) Insurance fees and commissions paid to agents, brokers, and other persons:
Amount of commissions paid: $1,035.19
Fees paid / amount: $0.00

a) Name & address of agent or broker to whom commission or fees were paid	b) Amount of Commission paid	Fees paid c) Amount	d) Purpose	e) Organization Code
KIBBLE & PRENTICE HOLDING CO PO BOX 62949 VIRGINIA BEACH, VA 23466	$961.90	$0.00	N/A	3
BROWN & BROWN OF FLORIDA INC 2290 LUCIEN WAY STE 400 MAITLAND, FL 32751	$3.63	$0.00	N/A	3
KIBBLE & PRENTICE HOLDING CO ATTN: USI NORTHWEST PO BOX 62949 VIRGINIA BEACH, VA 23466	$69.66*	$0.00	N/A	3

Total commissions paid: $965.53

Total contingent compensation paid: $69.66*

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Long Form Information

Part III - 162839
7) Benefit Type
E) TEMPORARY DISABILITY

8) Experience Rated Contracts

a) Premiums: (1) Amount Received	$8,656.59	
(2) Increase (decrease) in amount due but unpaid	$1,365.00	
(3) Increase (decrease) in unearned premium reserve	$0.00	
(4) Earned ((1) + (2) - (3))		$10,021.00
b) Benefit charges (1) Claims paid	$0.00	
(2) Increase (decrease) in claim reserves	$570.00	
(3) Incurred claims (add(1) and (2))		$570.00
(4) Claims charged		$570.00
c) Remainder of premium: (1) Retention charges(on an accrual basis)		
(A) Commissions	$1,035.19	
(B) Administrative service or other fees	$0.00	
(C) Other specific acquisition costs	$0.00	
(D) Other expenses	$1,949.00	
(E) Taxes	$40.00	
(F) Charges for risks or other contingencies	$701.00	
(G) Other retention charges	$5,725.81	
(H) Total retention		$9,451.00
(2) Dividends or retroactive rate refunds		$0.00
d) Status of policyholder reserves at end of year:		
(1) Amount held to provide benefits after retirement		$0.00
(2) Claim reserves		$1,348.00
(3) Other reserves		$0.00
e) Dividends or retroactive rate refunds due		$0.00

Standard Insurance Company hereby certifies that this information is complete and accurate.

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Long Form Information

The financial data below is provided for your information.
It can be used to complete the schedule a for the form 5500,
if your plan is required to file such a schedule.

c) Plan Sponsor: ABRASIVE FORM LLC

Part I
1) Coverage: - F) LONG TERM DISABILITY

a) Carrier: Standard Insurance Company
b) EIN: 93-0242990
c) NAIC code: 000-69019
D) Contract number: 162839
E) Number of persons covered: 234
F) From: 02/01/2020
G) To: 12/31/2020

2) Insurance fees and commissions paid to agents, brokers, and other persons:
Amount of commissions paid: $3,586.46
Fees paid / amount: $0.00

a) Name & address of agent or broker to whom commission or fees were paid	b) Amount of Commission paid	Fees paid c) Amount	d) Purpose	e) Organization Code
KIBBLE & PRENTICE HOLDING CO PO BOX 62949 VIRGINIA BEACH, VA 23466	$3,309.13	$0.00	N/A	3
BROWN & BROWN OF FLORIDA INC 2290 LUCIEN WAY STE 400 MAITLAND, FL 32751	$14.88	$0.00	N/A	3
KIBBLE & PRENTICE HOLDING CO ATTN: USI NORTHWEST PO BOX 62949 VIRGINIA BEACH, VA 23466	$262.45*	$0.00	N/A	3

Total commissions paid: $3,324.01

Total contingent compensation paid: $262.45*

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Long Form Information

Part III - 162839
7) Benefit Type
F) LONG TERM DISABILITY

8) Experience Rated Contracts

a) Premiums: (1) Amount Received	$29,184.56	
(2) Increase (decrease) in amount due but unpaid	$966.00	
(3) Increase (decrease) in unearned premium reserve	$0.00	
(4) Earned ((1) + (2) - (3))		$30,151.00
b) Benefit charges (1) Claims paid	$135,104.45	
(2) Increase (decrease) in claim reserves	$195,593.80	
(3) Incurred claims (add(1) and (2))		$330,698.25
(4) Claims charged		$330,698.25
c) Remainder of premium: (1) Retention charges(on an accrual basis)		
(A) Commissions	$3,586.46	
(B) Administrative service or other fees	$0.00	
(C) Other specific acquisition costs	$500.00	
(D) Other expenses	$18,186.00	
(E) Taxes	$121.00	
(F) Charges for risks or other contingencies	$3,355.55	
(G) Other retention charges	$0.00	
(H) Total retention		$25,749.01
(2) Dividends or retroactive rate refunds		$0.00
d) Status of policyholder reserves at end of year:		
(1) Amount held to provide benefits after retirement		$0.00
(2) Claim reserves		$662,390.49
(3) Other reserves		$0.00
e) Dividends or retroactive rate refunds due		$0.00

Standard Insurance Company hereby certifies that this information is complete and accurate.

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The Summary Annual Report…SAR

DS

I have reviewed the SAR.

The Summary Annual Report, also known by its acronym, the SAR, is, generally speaking, a one-page summary of the ERISA Plan's Form 5500 report. ERISA mandates for the SAR to be distributed to Plan Participants within two months from the Form 5500's due date (the SAR is not required to be issued if the plan is 100% self-funded such as a Health FSA plan).

The SAR's purpose is to inform the Plan Participants of the carriers and the policies included within the Form 5500 report. Additionally, funding is noted as well as the financials including the total premium spent and the claim total, if applicable.

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SUMMARY ANNUAL REPORT

For ABRASIVE-FORM LLC EMPLOYEE BENEFITS PLAN

This is a summary of the annual report of the ABRASIVE-FORM LLC EMPLOYEE BENEFITS PLAN, EIN 47-5282271, Plan No. 501, for period 02/01/2020 through 12/31/2020. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

ABRASIVE-FORM LLC has committed itself to pay certain self-funded Medical claims incurred under the terms of the plan.

Insurance Information

The plan has contracts with STANDARD INSURANCE COMPANY to pay Dental, Vision, Life Insurance, Short-term Disability, Long-term Disability, and Accidental Death and Dismemberment claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2020 were $200,419.

Because they are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 12/31/2020, the premiums paid under such "experience-rated" contracts were $200,419 and the total of all benefit claims paid under these contracts during the plan year was $517,798.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of ABRASIVE-FORM LLC at 454 SCOTT DRIVE, BLOOMINGDALE, IL, 60108 or by telephone at 630-893-7800.

You also have the legally protected right to examine the annual report at the main office of the plan (ABRASIVE-FORM LLC, 454 SCOTT DRIVE, BLOOMINGDALE, IL, 60108) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no

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persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 07/31/2023)