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

2022

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2022 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

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:
- [X] 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
- [X] 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
MAKAI HR LONG TERM DISABILITY

1b Three-digit plan number (PN) ▶ 105

1c Effective date of plan 10/01/2018

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)
KCPHI SERVICES, LLC
MAKAI HR

220 S KING ST STE 1430
HONOLULU, HI 96813-4526

220 S KING ST STE 1430
HONOLULU, HI 96813-4526

2b Employer Identification Number (EIN)
82-3809240

2c Plan Sponsor's telephone number
808-451-0000

2d Business code (see instructions)
561330

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.	05/12/2023	COURTNEY JACKSON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	05/12/2023	COURTNEY JACKSON
	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:	**4b**	EIN
a	Sponsor's name	**4d**	PN
c	Plan Name		

5	Total number of participants at the beginning of the plan year	**5**	68
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)**	68
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	134
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**	134
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	134
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:

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] 2 **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 2022 Form M-1 annual report. If the plan was not required to file the 2022 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

2022

This Form is Open to Public Inspection

For calendar plan year 2022 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
MAKAI HR LONG TERM DISABILITY

B Three-digit plan number (PN) ▶ 105

C Plan sponsor's name as shown on line 2a of Form 5500
KCPHI SERVICES, LLC

D Employer Identification Number (EIN)
82-3809240

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
RELIANCE STANDARD

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-0883760	68381	LTD130349	48	01/01/2019	12/31/2019

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
0	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

(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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(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** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [X] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	43		
(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)**	43
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**	
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? [X] Yes [ ] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2022

This Form is Open to Public Inspection

For calendar plan year 2022 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
MAKAI HR LONG TERM DISABILITY

B Three-digit plan number (PN) ▶ 105

C Plan sponsor's name as shown on line 2a of Form 5500
KCPHI SERVICES, LLC

D Employer Identification Number (EIN)
82-3809240

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
RELIANCE STANDARD

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-0883760	68381	VPL302964	84	01/01/2019	12/31/2019

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
0	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

(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	

(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** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [X] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	24		
(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)**	24
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**	
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. ▶

reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

April 28, 2023

INSURANCE INFORMATION
FORM 5500 - SCHEDULE A

KCPHI SERVICES, LLC DBA MAKAI HR
677 Ala Moana Blvd,
Suite 815
Honolulu, HI 96813

EIN: 36-0883760
NAIC: 68381
ORG. NUMBER: 3

Policyholder Name: KCPHI Services, LLC dba Makai HR
Policy Number: LTD 130349
Policy Type: LONG TERM DISABILITY
Number of Covered Employees: 48
Policy Contract Year: 1/1/2019 to 12/31/2019

	PREMIUM						
Benefits	**Premium**	**Rate 1**	**Eff**	**Rate 2**	**Eff**	**Rate 3**	**Eff**
Long Term Disability	$42.56	0.1300	10/18	0.0000	00/00	0.0000	
Total Premium:	**$42.56**						

COMPENSATION

Agent Code: 56-2859
Payee Name: Lum And Nakano Agency Inc.
Payee Address: 1221 Kapiolani Blvd PH30
Honolulu, HI 96814

Total Commission: $0.00
Total Administrative and Other Fees: $0.00
Total Amount of Compensation: $0.00

RGO: LOS ANGELES

*Compensation includes, but is not limited to the following: commissions, benefit administration fees, premier/elite producer payments and administrative fees.

reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

April 28, 2023

TO OUR GROUP POLICYHOLDERS WITH 100 OR MORE PLAN PARTICIPANTS

RE: EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)
(1) ANNUAL REPORT OF WELFARE BENEFIT PLAN - FORM 5500
(2) SUMMARY ANNUAL REPORT

(1) Section 104 of ERISA requires that each Plan Administrator who maintains a welfare benefit Plan subject to ERISA having 100 or more participants at any time during the plan year must file an annual report with the Department of Labor. The report must be filed within 7 months of the end of the plan year. Certain failures are provided for failure to comply.

As it appears your plan is subject to the Act, the data on the enclosed form is provided for your assistance in completing your annual report. By supplying this information it is not our intent to advise you as to your legal obligations under the act, nor do we wish to imply that this information constitutes all of the data to be included in our annual report.

If you expect to file an annual report, you would normally receive a complete copy of form 5500 and Schedule A from the Department of Labor, with all necessary instructions, prior to the filing date. Follow the instructions carefully. If you or your legal counsel have questions, please contact The Labor-Management Services Administration Office at the Department of Labor.

(2) Section 104(B) of ERISA requires a plan administrator who must file an annual report to also furnish a Summary Annual Report to each plan participant and beneficiary within 9 months of the end of your plan year and without charge.

The Summary Annual Report should include the following information:

1. The name of the plan as determined by your Plan Document and, if different, the name by which the plan is commonly known to its participants and beneficiaries; and
2. The name and business address (do not use P.O. Box number) of the Plan Sponsor (usually the employer to whom the policy was issued). However, if different, show:
    a. The name and address of any employer having employees covered by the plan; or
    b. The name and address of any labor organization maintaining the plan; or
    c. In case of a plan established or maintained by two or more employers or by one or more employers and one or more employee organizations, the name and address of the association, committee, joint board of trustees, parent, or most significant employer of a group of employees contributing to the same plan; and
3. The name, business address, (do not use P.O. Box number) and business telephone number of the Plan Administrator; and
4. A statement of assets and liabilities stated at current value; and
5. Separate or combined statements of income and expenses and changes in net assets; and
6. Such other materials as are necessary to fairly summarize the Annual Report.
7. A notice which says, for example: Plan participants and beneficiaries may obtain copies of the Annual Report filed with the Department of Labor by making a written request to the Plan Administrator. A reasonable charge will be made; or you may inspect the report without charge at the office of (give name and address, usually the Plan Administrators; or if the plan covers participants at various locations, you may be required to have a copy available at each location. If so, list the locations).

The above information with respect to the contents of the Summary Annual Report is based on our interpretation of the Act. It is not our intention to advise you as to your obligations regarding compliance under the Act. We suggest that you consult with your own legal counsel and discuss the requirements before any action is taken.

Customer Service
1-800-644-1103

reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

April 28, 2023

INSURANCE INFORMATION
FORM 5500 - SCHEDULE A

KCPHI SERVICES, LLC DBA MAKAI HR
677 Ala Moana Blvd,
Suite 815
Honolulu, HI 96813

EIN: 36-0883760
NAIC: 68381
ORG. NUMBER: 3

Policyholder Name: KCPHI Services, LLC dba Makai HR
Policy Number: VPL 302964
Policy Type: VOLUNTARY LONG TERM DISABILITY
Number of Covered Employees: 84
Policy Contract Year: 1/1/2019 to 12/31/2019

	PREMIUM						
Benefits	**Premium**	**Rate 1**	**Eff**	**Rate 2**	**Eff**	**Rate 3**	**Eff**
Long Term Disability	$23.67	0.9999	00/00	0.0000	00/00	0.0000	
Total Premium:	**$23.67**						

COMPENSATION

Agent Code: 56-2859
Payee Name: Lum And Nakano Agency Inc.
Payee Address: 1221 Kapiolani Blvd PH30
Honolulu, HI 96814

Total Commission: $0.00
Total Administrative and Other Fees: $0.00
Total Amount of Compensation: $0.00

RGO: LOS ANGELES

*Compensation includes, but is not limited to the following: commissions, benefit administration fees, premier/elite producer payments and administrative fees.

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April 28, 2023

TO OUR GROUP POLICYHOLDERS WITH 100 OR MORE PLAN PARTICIPANTS

RE: EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)
(1) ANNUAL REPORT OF WELFARE BENEFIT PLAN - FORM 5500
(2) SUMMARY ANNUAL REPORT

(1) Section 104 of ERISA requires that each Plan Administrator who maintains a welfare benefit Plan subject to ERISA having 100 or more participants at any time during the plan year must file an annual report with the Department of Labor. The report must be filed within 7 months of the end of the plan year. Certain failures are provided for failure to comply.

As it appears your plan is subject to the Act, the data on the enclosed form is provided for your assistance in completing your annual report. By supplying this information it is not our intent to advise you as to your legal obligations under the act, nor do we wish to imply that this information constitutes all of the data to be included in our annual report.

If you expect to file an annual report, you would normally receive a complete copy of form 5500 and Schedule A from the Department of Labor, with all necessary instructions, prior to the filing date. Follow the instructions carefully. If you or your legal counsel have questions, please contact The Labor-Management Services Administration Office at the Department of Labor.

(2) Section 104(B) of ERISA requires a plan administrator who must file an annual report to also furnish a Summary Annual Report to each plan participant and beneficiary within 9 months of the end of your plan year and without charge.

The Summary Annual Report should include the following information:

1. The name of the plan as determined by your Plan Document and, if different, the name by which the plan is commonly known to its participants and beneficiaries; and
2. The name and business address (do not use P.O. Box number) of the Plan Sponsor (usually the employer to whom the policy was issued). However, if different, show:
    a. The name and address of any employer having employees covered by the plan; or
    b. The name and address of any labor organization maintaining the plan; or
    c. In case of a plan established or maintained by two or more employers or by one or more employers and one or more employee organizations, the name and address of the association, committee, joint board of trustees, parent, or most significant employer of a group of employees contributing to the same plan; and
3. The name, business address, (do not use P.O. Box number) and business telephone number of the Plan Administrator; and
4. A statement of assets and liabilities stated at current value; and
5. Separate or combined statements of income and expenses and changes in net assets; and
6. Such other materials as are necessary to fairly summarize the Annual Report.
7. A notice which says, for example: Plan participants and beneficiaries may obtain copies of the Annual Report filed with the Department of Labor by making a written request to the Plan Administrator. A reasonable charge will be made; or you may inspect the report without charge at the office of (give name and address, usually the Plan Administrators; or if the plan covers participants at various locations, you may be required to have a copy available at each location. If so, list the locations).

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