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 01/01/2018 and ending 12/31/2018

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
- [X] a DFE (specify) G

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

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

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

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
MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURANCE TRUST

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 04/01/1953

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)
MASS BANKERS ASSOC GROUP INS TRUST

ONE WASHINGTON MALL
BOSTON, MA 02108

ONE WASHINGTON MALL
BOSTON, MA 02108

2b Employer Identification Number (EIN)
04-2628271

2c Plan Sponsor's telephone number
617-523-7595

2d Business code (see instructions)
524290

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.	08/03/2023	CHAD POOK
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	08/03/2023	KATHLEEN M. MURPHY
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Filed with authorized/valid electronic signature.	08/03/2023	CHAD POOK
	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**	10800
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)**	10100
a(2) Total number of active participants at the end of the plan year	**6a(2)**	9001
b Retired or separated participants receiving benefits	**6b**	600
c Other retired or separated participants entitled to future benefits	**6c**	
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	9601
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 4D 4L

9a Plan funding arrangement (check all that apply)

(1)	[X]	Insurance
(2)	[ ]	Code section 412(e)(3) insurance contracts
(3)	[X]	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)	[X]		**H** (Financial Information)
(2)	[ ]		**I** (Financial Information – Small Plan)
(3)	[X]	6	**A** (Insurance Information)
(4)	[X]		**C** (Service Provider Information)
(5)	[X]		**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.) ..... [X] 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.) ..... [X] 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 74892481

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 01/01/2018 and ending 12/31/2018

A Name of plan
MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MASS BANKERS ASSOC GROUP INS TRUST

D Employer Identification Number (EIN)
04-2628271

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
BLUE CROSS/BLUE SHIELD OF MA - MEDEX

(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
04-1045815	53228	MULTIPLE	597	01/01/2018	12/31/2018

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	

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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	

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)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below) ▶	**7e(4)**			
	(5) Total deductions			**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	1156814		
(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)**	1156814
b Benefit charges (1) Claims paid	**9b(1)**	922075		
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	922075
(4) Claims charged			**9b(4)**	937750
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)**	219064		
(H) Total retention			**9c(1)(H)**	219064
(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. ▶

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 01/01/2018 and ending 12/31/2018

A Name of plan
MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MASS BANKERS ASSOC GROUP INS TRUST

D Employer Identification Number (EIN)
04-2628271

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
A.I.G - BUSINESS TRAVEL ACCIDENT

(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
25-0687550	19445	GTP 0009101853	7900	01/01/2018	12/31/2018

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
6381	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

MASS FINANCIAL SERVICES INS. AGENCY
1 WASHINGTON MALL STE 800
BOSTON, MA 02108-2618

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
6381			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)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below) ▶	**7e(4)**			
	(5) Total deductions			**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

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	42550
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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OMB No. 1210-0110

2022

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For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan
MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MASS BANKERS ASSOC GROUP INS TRUST

D Employer Identification Number (EIN)
04-2628271

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
BLUE CROSS BLUE SHIELD OF MA-DENTAL

(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
04-1045815	53228	MULTIPLE	8803	01/01/2018	12/31/2018

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

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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. 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)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below) ▶	**7e(4)**			
	(5) Total deductions			**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	9328505		
(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)**	9328505
b Benefit charges (1) Claims paid	**9b(1)**	8437087		
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	8437087
(4) Claims charged			**9b(4)**	8631140
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)**	110076		
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**	587288		
(H) Total retention			**9c(1)(H)**	697364
(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. ▶

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 01/01/2018 and ending 12/31/2018

A Name of plan
MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MASS BANKERS ASSOC GROUP INS TRUST

D Employer Identification Number (EIN)
04-2628271

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
BLUE CROSS/BLUE SHIELD-MEDICAL

(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
04-1045815	53228	MULTIPLE	8726	01/01/2018	12/31/2018

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)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below) ▶	**7e(4)**			
	(5) Total deductions			**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	134743849		
(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)**	134743849
b Benefit charges (1) Claims paid	**9b(1)**	120361260		
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	120361260
(4) Claims charged			**9b(4)**	122374387
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)**	280776		
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**	12088687		
(H) Total retention			**9c(1)(H)**	12369463
(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. ▶

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 01/01/2018 and ending 12/31/2018

A Name of plan
MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MASS BANKERS ASSOC GROUP INS TRUST

D Employer Identification Number (EIN)
04-2628271

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

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
THE HARTFORD

(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
06-0838648	70815	MULTIPLE	10753	01/01/2018	12/31/2018

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)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below) ▶	**7e(4)**			
	(5) Total deductions			**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [ ] 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 & DISBURSEMENT

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	1951560
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

2022

This Form is Open to Public Inspection

For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan
MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MASS BANKERS ASSOC GROUP INS TRUST

D Employer Identification Number (EIN)
04-2628271

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
VISION SERVICE PLAN

(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
06-1227840	39616	MULTIPLE	6357	01/01/2018	12/31/2018

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
76100	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

MASS FINANCIAL SERVICES INS. AGENCY
1 WASHINGTON MALL STE 800
BOSTON, MA 02108-2618

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
76100			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)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below) ▶	**7e(4)**			
	(5) Total deductions			**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	1271624		
(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)**	1271624
b Benefit charges (1) Claims paid	**9b(1)**	1064544		
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	1064544
(4) Claims charged			**9b(4)**	1064544
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	76100		
(B) Administrative service or other fees	**9c(1)(B)**	216176		
(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)**	292276
(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. ▶

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2022** **This Form is Open to Public Inspection.**

For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan	**B** Three-digit plan number (PN) ▶
MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURANCE TRUST	501

C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
MASS BANKERS ASSOC GROUP INS TRUST	04-2628271

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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

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

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

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

MASS FIN SERVICES INS AGENCY

04-2680895

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13	NONE	0	Yes [X] No [ ]	Yes [X] No [ ]	1082546	Yes [ ] No [X]

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

LIBERTE GROUP LLC

26-2435423

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	17900	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

WOLF & COMPANY, P.C.

04-2689883

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	11958	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500)	DFE/Participating Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	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.**	**2022** **This Form is Open to Public Inspection.**

For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan	**B** Three-digit plan number (PN) ▶
MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURANCE TRUST	501

C Plan or DFE sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
MASS BANKERS ASSOC GROUP INS TRUST	04-2628271

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)

(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	ADAMS COMMUNITY BANK	**c** EIN-PN	04-1851620-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	ATHOL SAVINGS BANK	**c** EIN-PN	04-1046670-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	BANK OF CANTON	**c** EIN-PN	04-1148230-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	BELMONT SAVINGS BANK	**c** EIN-PN	04-1078435-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	ONEUNITED BANK	**c** EIN-PN	04-2764211-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	BRIDGEWATER SAVINGS BANK	**c** EIN-PN	04-1118820-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	BRISTOL COUNTY SAVINGS BANK	**c** EIN-PN	04-3317338-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	BROOKLINE BANK	**c** EIN-PN	04-1125010-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	CAPE ANN SAVINGS BANK	**c** EIN-PN	04-1148820-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	THE COOPERATIVE BANK OF CAPE COD	**c** EIN-PN	04-1148930-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	CAPE COD FIVE CENTS SAVINGS BANK	**c** EIN-PN	04-1149070-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	CENTURY BANK	**c** EIN-PN	04-6202762-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	BAYCOAST BANK	**c** EIN-PN	04-1178460-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	CLINTON SAVINGS BANK	**c** EIN-PN	04-1185690-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	COUNTRY BANK FOR SAVINGS	**c** EIN-PN	04-1946610-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	DEAN BANK	**c** EIN-PN	04-1237280-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	DEDHAM INSTITUTION FOR SAVINGS	**c** EIN-PN	04-1238700-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MARTHA'S VINEYARD SAVINGS BANK	**c** EIN-PN	04-2188463-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	EAST BOSTON SAVINGS BANK	**c** EIN-PN	04-3130808-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	EAST CAMBRIDGE SAVINGS BANK	**c** EIN-PN	04-1269550-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	BANK ESB/EASTHAMPTON SAVINGS BANK	**c** EIN-PN	04-1272090-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	ENTERPRISE BANK & TRUST COMPANY	**c** EIN-PN	04-2993547-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	BANK FIVE	**c** EIN-PN	41-2178171-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	FAMILY FEDERAL SAVINGS BANK	**c** EIN-PN	04-1328570-501

Part II Information on Participating Plans (to be completed by DFEs)

(Complete as many entries as needed to report all participating plans)

a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	RADIUS BANK	**c** EIN-PN	04-2960120-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	ROLLSTONE BANK & TRUST	**c** EIN-PN	04-1328870-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MUTUAL ONE BANK	**c** EIN-PN	04-1339820-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	BANKGLOUCESTER	**c** EIN-PN	04-1371820-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	GREENFIELD SAVINGS BANK	**c** EIN-PN	81-0669576-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	HINGHAM INSTITUTION FOR SAVINGS	**c** EIN-PN	04-1442480-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MOUNTAINONE BANK	**c** EIN-PN	04-3413060-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	AVIDIA BANK	**c** EIN-PN	04-3395834-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	COMMONWEALTH CO-OPERATIVE BANK	**c** EIN-PN	04-1465980-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	INSTITUTION FOR SAVINGS NEWBURYPORT	**c** EIN-PN	04-1471660-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	BEVERLY BANK	**c** EIN-PN	04-1087180-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	LEE BANK	**c** EIN-PN	04-3158399-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	LOWELL FIVE CENT SAVINGS BANK	**c** EIN-PN	45-3131005-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MANSFIELD BANK	**c** EIN-PN	04-1578690-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MARBLEHEAD BANK	**c** EIN-PN	04-1580550-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MAIN STREET BANK	**c** EIN-PN	04-1584100-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MASSACHUSETTS BANKERS ASSOCIATION	**c** EIN-PN	04-1589780-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MECHANICS CO-OPERATIVE BANK	**c** EIN-PN	04-1608620-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	CHARLES RIVER BANK	**c** EIN-PN	04-1609550-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MIDDLESEX FEDERAL SAVINGS, F.A.	**c** EIN-PN	04-1618915-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MIDDLESEX SAVINGS BANK	**c** EIN-PN	27-0402195-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MILFORD FEDERAL BANK	**c** EIN-PN	04-1620675-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MILFORD NATIONAL BANK	**c** EIN-PN	04-1620797-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MILLBURY NATIONAL BANK	**c** EIN-PN	04-1621330-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MILLBURY SAVINGS BANK	**c** EIN-PN	04-1621370-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MONSON SAVINGS BANK	**c** EIN-PN	56-2545442-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	PATRIOT COMMUNITY BANK	**c** EIN-PN	20-3411700-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	NATIONAL GRAND BANK OF MARBLEHEAD	**c** EIN-PN	04-2832782-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	NEEDHAM BANK	**c** EIN-PN	04-1655620-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	NEWBURYPORT FIVE CENTS SAVINGS BANK	**c** EIN-PN	04-1669070-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	NEW ENGLAND AUTOMATED CLEARING HOUSE	**c** EIN-PN	04-2514013-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	NORTH BROOKFIELD SAVINGS BANK	**c** EIN-PN	04-1677290-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	NORTH CAMBRIDGE CO-OPERATIVE BANK	**c** EIN-PN	04-1677300-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	NORTH EASTON SAVINGS BANK	**c** EIN-PN	04-1677530-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	NORTHEAST RETIREMENT SERVICES	**c** EIN-PN	04-2686260-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	NORTH MIDDLESEX SAVINGS BANK	**c** EIN-PN	04-1678010-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	NORTH SHORE BANK	**c** EIN-PN	04-3414678-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	NORWOOD BANK	**c** EIN-PN	04-1680920-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	PENTUCKET BANK	**c** EIN-PN	04-1715580-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	PEOPLES SAVINGS BANK, HOLYOKE	**c** EIN-PN	04-1716200-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	PILGRIM BANK	**c** EIN-PN	04-1728400-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	PROVIDENT BANK	**c** EIN-PN	04-1746360-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	ENVISION BANK	**c** EIN-PN	74-3073286-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	THE SAVINGS BANK	**c** EIN-PN	04-1939290-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	SEAMEN'S BANK	**c** EIN-PN	04-1817540-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	S-BANK	**c** EIN-PN	04-1852680-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	STOUGHTON COOPERATIVE BANK	**c** EIN-PN	04-1875980-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	WAKEFIELD COOPERATIVE BANK	**c** EIN-PN	04-1939190-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	WALPOLE CO-OPERATIVE BANK	**c** EIN-PN	04-1943030-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	WASHINGTON SAVINGS BANK	**c** EIN-PN	04-1949430-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	WATERTOWN SAVINGS BANK	**c** EIN-PN	04-1950840-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	WEBSTER FIVE CENTS SAVINGS BANK	**c** EIN-PN	04-1953630-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	WESTFIELD BANK	**c** EIN-PN	04-3305700-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	WINCHESTER CO-OPERATIVE BANK	**c** EIN-PN	04-1978070-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	WINCHESTER SAVINGS BANK	**c** EIN-PN	04-1978230-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	WINTER HILL BANK	**c** EIN-PN	04-1980523-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	WRENTHAM CO-OPERATIVE BANK	**c** EIN-PN	04-1991475-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	BANK OF EASTON	**c** EIN-PN	04-1677520-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	CANTON COOPERATIVE BANK	**c** EIN-PN	04-1207730-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	COLONIAL COOPERATIVE BANK	**c** EIN-PN	04-1166100-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	COLONIAL FEDERAL SAVINGS BANK	**c** EIN-PN	04-1983105-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	COOPERATIVE BANK EMP RET ASSOC	**c** EIN-PN	04-6035593-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	DEPOSITORS INSURANCE FUND	**c** EIN-PN	04-1647690-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	EQUITABLE COOPERATIVE BANK	**c** EIN-PN	04-1290470-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	EVERETT COOPERATIVE BANK	**c** EIN-PN	04-1294820-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	FLORENCE SAVINGS BANK	**c** EIN-PN	04-1332530-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	FOXBOROUGH FEDERAL SAVINGS BANK	**c** EIN-PN	04-1339492-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	HAVERHILL BANK	**c** EIN-PN	04-1426920-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MASS. BUSINESS DEVELOPMENT	**c** EIN-PN	04-2163213-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	METHUEN COOPERATIVE BANK	**c** EIN-PN	04-0615835-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	MUTUAL BANK	**c** EIN-PN	04-1647485-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	ABINGTON BANK	**c** EIN-PN	04-1676630-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	SAVERS BANK	**c** EIN-PN	04-1853350-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	SAVINGS BANK LIFE INSURANCE COUNCIL	**c** EIN-PN	04-3117253-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	WELLESLEY BANK	**c** EIN-PN	04-1956610-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	GREENFIELD CO-OPERATIVE BANK	**c** EIN-PN	04-1400390-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	LEADER BANK	**c** EIN-PN	04-3557920-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	HARBOR ONE	**c** EIN-PN	04-1123040-501
a Plan name	MASS BANKER ASSOC GROUP INS TRUST		
b Name of plan sponsor	CAMBRIDGE SAVINGS BANK	**c** EIN-PN	04-1145100-501
a Plan name			
b Name of plan sponsor		**c** EIN-PN	
a Plan name			
b Name of plan sponsor		**c** EIN-PN	
a Plan name			
b Name of plan sponsor		**c** EIN-PN	
a Plan name			
b Name of plan sponsor		**c** EIN-PN	
a Plan name			
b Name of plan sponsor		**c** EIN-PN	

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

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

OMB No. 1210-0110

2022

This Form is Open to Public Inspection

For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan
MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MASS BANKERS ASSOC GROUP INS TRUST

D Employer Identification Number (EIN)
04-2628271

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	18314	27367
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	2595072	4558069
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	2613386	4585436
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h	0	2600
i Acquisition indebtedness	1i		
j Other liabilities	1j	32182	139907
k Total liabilities (add all amounts in lines 1g through1j)	1k	32182	142507
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	2581204	4442929

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	42537	
(B) Participants	2a(1)(B)		
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		42537
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	34995	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		34995
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		2430135
d Total income. Add all **income** amounts in column (b) and enter total	2d		2507667
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		
(2) To insurance carriers for the provision of benefits	2e(2)	36157	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		36157
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)	31957	
(2) Contract administrator fees	2i(2)	566041	
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	11787	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		609785
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		645942
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		1861725
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) [X] Unmodified **(2)** [ ] Qualified **(3)** [ ] Disclaimer **(4)** [ ] Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) [ ] DOL Regulation 2520.103-8 **(2)** [ ] DOL Regulation 2520.103-12(d) **(3)** [ ] neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: WOLF & COMPANY, P.C. **(2)** EIN: 04-2689883

d The opinion of an independent qualified public accountant is **not attached** because:

(1) [ ] This form is filed for a CCT, PSA, or MTIA. **(2)** [ ] It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.

During the plan year:

		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a			

		Yes	No	Amount
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e Was this plan covered by a fidelity bond?	4e			
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f			
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g			
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h			
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	4j	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k			
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? ☐ Yes ☐ No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ☐ Yes ☐ No ☐ Not determined
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

WOLF
& COMPANY, P.C.

Massachusetts Bankers Association
Group Insurance Trust

Financial Statements and Supplemental Schedules

Years Ended December 31, 2018 and 2017

Massachusetts Bankers Association
Group Insurance Trust

E.I.N. 04-2628271 Plan Number 501

Financial Statements and Supplemental Schedules
for the Years Ended December 31, 2018 and 2017

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WOLF
& COMPANY, P.C.

Independent Auditor's Report

To the Board of Trustees of the Massachusetts Bankers Association Group Insurance Trust:

Report on the Financial Statements

We have audited the accompanying financial statements of the Massachusetts Bankers Association Group Insurance Trust (the "Trust") which comprise the statements of net assets available for benefits as of December 31, 2018 and 2017 and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of the Massachusetts Bankers Association Group Insurance Trust as of December 31, 2018 and 2017, and the changes in its financial status for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter – Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The supplemental schedules of assets (held at end of year) and reportable transactions as of or for the year ended December 31, 2018 are presented for the purpose of additional analysis and are not a required part of the basic financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. Such information is the responsibility of the Plan's Trustees and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Wolf + Company, P.C.

Boston, Massachusetts
April 12, 2019

Massachusetts Bankers Association
Group Insurance Trust

Statements of Net Assets Available for Benefits

December 31, 2018 and 2017

	2018	2017
Assets		
Cash and cash equivalents	$ 2,958,069	$ 1,095,072
Investments:		
Certificates of deposit	1,600,000	1,500,000
Accrued interest receivable	27,367	14,714
Prepaid income taxes	-	3,600
Total assets	4,585,436	2,613,386
Liabilities		
Accounts payable and accrued expenses	2,600	-
Unearned premium income	-	32,182
Income taxes payable	4,900	-
Due to affiliate	135,007	-
Total liabilities	142,507	32,182
Net assets available for benefits	$ 4,442,929	$ 2,581,204

The accompanying notes are an integral part of these financial statements.

Massachusetts Bankers Association
Group Insurance Trust

Statements of Changes in Net Assets Available for Benefits

Years Ended December 31, 2018 and 2017

	2018	2017
Additions:		
Risk sharing arrangement	$ 2,415,254	$ -
Premium income from member banks	42,537	46,415
Interest income	34,995	19,355
Performance guarantee	14,314	-
Other income	567	-
Total additions	2,507,667	65,770
Deductions:		
Premiums paid to insurance carriers	36,157	39,453
Administrative fees paid to affiliate	566,041	6,962
Income taxes	11,787	7,890
Legal and accounting	31,957	27,418
Total deductions	645,942	81,723
Net increase (decrease)	1,861,725	(15,953)
Net assets available for benefits:		
Beginning of year	2,581,204	2,597,157
End of year	$ 4,442,929	$ 2,581,204

The accompanying notes are an integral part of these financial statements.

Massachusetts Bankers Association
Group Insurance Trust

Notes to Financial Statements

Years Ended December 31, 2018 and 2017

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

General

The Massachusetts Bankers Association Group Insurance Trust (the "Trust") is a group insurance arrangement operated for the purpose of providing group insurance coverage to member banks' employees at costs that are generally less than those obtainable on an individual bank basis. For Business Travel Accident insurance, premium income is earned and billed annually by the Trust, based on member banks' plan design and enrollment. Premiums for medical and dental coverage under the Trust are billed by and paid directly to the insurance companies.

Trust Amendment

The Trust Agreement was amended and restated in its entirety, effective as of January 1, 2014, to update the Trust Agreement to reflect provisions to comply with the Patient Protection and Affordable Care Act ("PPACA") and the Health Care Education and Reconciliation Act, as amended, and the regulations thereunder; and to provide for the continued qualification of the Trust as a voluntary employees' beneficiary association within the meaning of Section 501(c)(9) of the Internal Revenue Code (the "Code").

Effective January 1, 2014, the Trust established The Massachusetts Bankers Association Group Insurance Plan (the "Plan") to continue the operation of the Trust's long-standing group insurance program, to formalize the role of the Trust as the sponsor and administrator of the Plan, to clarify the process by which participating member banks may adopt the Plan, and to further clarify that the Plan, as set forth herein, is intended to constitute a large employer for purposes of the PPACA, a single employee welfare benefit plan under Section 3(1) of ERISA, and a single accident or health plan under Section 105(e) of the Code.

Basis of Presentation

The accompanying financial statements have been prepared on the accrual basis of accounting.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and changes therein and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (concluded)

Cash and Cash Equivalents

Cash and cash equivalents include money market accounts and cash balances with an original maturity of three months or less when purchased. The Trust may maintain cash and cash equivalent deposits in excess of federally insured limits at certain financial institutions. The Trust has not experienced any losses in such accounts and does not believe it is exposed to significant credit risks.

Certificates of Deposit

The Trust invests in certificates of deposit with interest income being recognized in the period earned. Due to the short-term nature of the certificates of deposit, they are stated at cost, which approximates fair value.

Unearned Premium Income

Unearned premium income represents payments received by the Trust from its member banks for premiums associated with future coverage.

Due to Affiliate

Amounts due to affiliate represent amounts due to the Massachusetts Bankers Association, Inc. and Subsidiary in the normal course of performing the Trust's activities.

2. INVESTMENTS

Certificates of deposit mature as follows at December 31, 2018 and 2017:

	2018	2017
Due in 2018	$ -	$ 1,150,000
Due in 2019	750,000	350,000
Due in 2020	750,000	-
Due in 2021	100,000	-
Total certificates of deposit	$ 1,600,000	$ 1,500,000

3. INSURANCE CONTRACTS

The Trust entered into a risk sharing arrangement with Blue Cross Blue Shield for the 2012 policy year whereby the Trust and Blue Cross share excess premiums, as defined, with such amounts to be determined in the following policy year. The arrangement automatically renews each year. During 2018, subsequent to the claim period for the 2017 policy year, which ended on June 30, 2018, the Trust received $2,415,254 in connection with the 2017 risk sharing arrangement. There were no amounts received during 2017 in connection with the 2016 risk sharing arrangement.

At December 31, 2018, the amount, if any, that the Trust will receive in 2019 in connection with the 2018 risk sharing arrangement cannot be reasonably estimated. The claim period, for which payments can still be made by Blue Cross for claims relating to the 2018 policy year, ends June 30, 2019. Therefore, the 2018 risk share arrangement amounts will not be determined until subsequent to June 30, 2019. As a result, the Trust has not recorded a receivable nor recognized risk sharing arrangement revenue relating to the 2018 policy year on the Statement of Net Assets Available for Benefits for the year ended December 31, 2018.

4. PERFORMANCE GUARANTEES

The Trust maintains agreements (the "Agreements") with insurance carriers (the "Carriers") which provide for certain administrative performance guarantees such as claim processing timeliness and accuracy, and reporting of performance levels by the Carriers. Failure by the Carriers to comply with the Agreements triggers certain fees to be paid to the Trust. No performance guarantee fees from the medical and dental plans have been recognized or received relating to 2018. During 2018, the Trust recognized performance guarantee fees of $14,314 relating to 2017. No performance guarantee fees from the medical and dental plans were recognized or received in 2017 relating to 2016.

At December 31, 2018, the amount, if any, that the Trust will receive in 2019 for performance guarantee fees from the medical and dental plans relating to 2018 cannot be reasonably estimated. As a result, the Trust has not recorded a receivable nor performance guarantee revenue relating to the 2018 plan year on the Statement of Net Assets Available for Benefits for the year ended December 31, 2018.

5. ADMINISTRATIVE FEES

Member banks and certain third-party vendors remit some payments to the Trust for insurance premiums and administrative fees. While most premiums are paid directly to the respective insurance carriers, administrative fees are forwarded to the MBA Service Corporation and Subsidiaries (the "Corporation") (a wholly-owned subsidiary of the Massachusetts Bankers Association, Inc. (the "Association")). The administrative fees are connected with certain administrative services provided by the Association for various insurance and employee benefit programs.

In connection with the renewal of the 2018 medical plan with Blue Cross Blue Shield, the administrative fee previously paid by Blue Cross to the Corporation was applied to the premium rates. As a result, the Trust's administrative fees paid to the Corporation were increased by $559,661. Administrative fees paid by the Trust to the Corporation amounted to $566,041 and $6,962 for 2018 and 2017, respectively.

6. BENEFIT OBLIGATIONS

Since the group insurance arrangement of the Trust is fully insured, there is no unfunded benefit obligation and, accordingly, no change in the benefit obligation for 2018 and 2017.

7. TAX STATUS

The Trust obtained its latest determination letter on February 16, 1977, in which the Internal Revenue Service stated that the Trust, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code. The Trust was most recently amended effective January 1, 2014 as indicated in Note 1 to the financial statements. Although the Trust has been amended since receiving the determination letter, the Plan Administrator and the Trust's tax counsel believe that the Trust is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code and therefore believe that the Trust is tax-exempt.

The Trust is a tax exempt organization as described in Section 501(c)(9) of the Internal Revenue Code, and is generally exempt from federal taxes pursuant to Section 501(a) of the Code. However, the Trust is subject to Federal and Massachusetts income tax on unrelated taxable income generated from investments and realized capital gains.

Tax positions taken or expected to be taken in the course of preparing the Trust's tax returns, including the position that the Trust qualifies as a tax exempt organization, are required to be evaluated to determine whether the tax positions are "more-likely-than-not" to be upheld under regulatory review. The Trust does not have any uncertain tax positions at December 31, 2018 and 2017 which require disclosure or accrual. The Trust is currently open to audit under applicable statutes of limitation by federal and state tax authorities for the years ended December 31, 2015 through 2018.

TAX STATUS (concluded)

The provision for income taxes consists of the following:

	2018	2017
Federal	$ 10,600	$ 6,800
State	1,187	1,090
Total	$ 11,787	$ 7,890

8. SUBSEQUENT EVENTS

Management has evaluated subsequent events through April 12, 2019, which is the date the financial statements were available to be issued. There were no subsequent events that require adjustment to or disclosure in the financial statements.

Massachusetts Bankers Association Group Insurance Trust

Schedule H, Line 4i - Schedule of Assets (Held at End of Year)

E.I.N. 04-2628271 Plan Number 501

December 31, 2018

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or maturity	(d) Cost	(e) Current Value
	Needham Bank	Certificate of deposit, 1.29% due 1/5/19	$ 250,000	$ 250,000
	Cornerstone Bank	Certificate of deposit, 1.65% due 9/17/19	100,000	100,000
	Institution for Savings	Certificate of deposit, 2.23% due 10/21/19	150,000	150,000
	Pilgrim Bank	Certificate of deposit, 2.23% due 11/8/19	250,000	250,000
	Institution for Savings	Certificate of deposit, 2.47%, due 2/9/20	100,000	100,000
	Pilgrim Bank	Certificate of deposit, 2.96% due 2/10/20	150,000	150,000
	Main Street Bank	Certificate of deposit, 2.10% due 5/8/20	250,000	250,000
	Century Bank	Certificate of deposit, 2.47% due 6/8/20	250,000	250,000
	Blue Hills Bank	Certificate of deposit, 2.96% due 1/9/21	100,000	100,000
	Total investments		$ 1,600,000	$ 1,600,000

There were no investment assets which were both acquired and disposed of during the plan year.

See independent auditor's report.

Massachusetts Bankers Association Group Insurance Trust

Schedule H, Line 4j - Schedule of Reportable Transactions

E.I.N. 04-2628271 Plan Number 501

Year Ended December 31, 2018

(a) Identity of party involved	(b) Description of asset (include interest rate and maturity in case of a loan)	(c) Purchase price	(d) Selling price	(e) Lease rental	(f) Expense incurred with transaction	(g) Cost of asset	(h) Current value of asset on transaction date	(i) Net gain or (loss)
Category (1) - A single transaction in excess of 5% of plan assets:								
Institution for Savings	-Maturity of CD, 1.00%, due 2/21/18	$ -	$ 150,000	$ -	$ -	$ 150,000	$ 150,000	$ -
Institution for Savings	-Maturity of CD, 1.00%, due 6/9/18	-	250,000	-	-	250,000	250,000	-
Pilgrim Bank	-Maturity of CD, 1.48%, due 8/8/18	-	250,000	-	-	250,000	250,000	-
Main Street Bank	-Maturity of CD, 1.25%, due 11/8/18	-	250,000	-	-	250,000	250,000	-
Century Bank	-Maturity of CD, 1.74%, due 12/8/18	-	250,000	-	-	250,000	250,000	-
Institution for Savings	-Purchase of CD, 2.23%, due 10/21/19	150,000	-	-	-	150,000	150,000	-
Pilgrim Bank	-Purchase of CD, 2.23%, due 11/8/19	250,000	-	-	-	250,000	250,000	-
Pilgrim Bank	-Purchase of CD, 2.96%, due 2/10/20	150,000	-	-	-	150,000	150,000	-
Main Street Bank	-Purchase of CD, 2.10%, due 5/8/20	250,000	-	-	-	250,000	250,000	-
Century Bank	-Purchase of CD, 2.47%, due 6/8/20	250,000	-	-	-	250,000	250,000	-
Category (2) - A series of transactions with the same person involving property other than securities and aggregating to more than 5% of plan assets:								
None								
Category (3) - A series of securities transactions in excess of 5% of plan assets:								
Institution for Savings	-Maturity of CD, 1.00%, due 2/21/18	$ -	$ 150,000	$ -	$ -	$ 150,000	$ 150,000	$ -
Institution for Savings	-Maturity of CD, 1.00%, due 6/9/18	-	250,000	-	-	250,000	250,000	-
Pilgrim Bank	-Maturity of CD, 1.48%, due 8/8/18	-	250,000	-	-	250,000	250,000	-
Main Street Bank	-Maturity of CD, 1.25%, due 11/8/18	-	250,000	-	-	250,000	250,000	-
Century Bank	-Maturity of CD, 1.74%, due 12/8/18	-	250,000	-	-	250,000	250,000	-
Institution for Savings	-Purchase of CD, 2.23%, due 10/21/19	150,000	-	-	-	150,000	150,000	-
Pilgrim Bank	-Purchase of CD, 2.23%, due 11/8/19	250,000	-	-	-	250,000	250,000	-
Pilgrim Bank	-Purchase of CD, 2.96%, due 2/10/20	150,000	-	-	-	150,000	150,000	-
Main Street Bank	-Purchase of CD, 2.10%, due 5/8/20	250,000	-	-	-	250,000	250,000	-
Century Bank	-Purchase of CD, 2.47%, due 6/8/20	250,000	-	-	-	250,000	250,000	-
Category (4) - A single transaction with the same person in excess of 5% of plan assets.								
None								

See independent auditor's report.

Massachusetts Bankers Association Group Insurance Trust

Schedule H, Line 4i - Schedule of Assets (Held at End of Year)

E.I.N. 04-2628271 Plan Number 501

December 31, 2018

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or maturity	(d) Cost	(e) Current Value
	Needham Bank	Certificate of deposit, 1.29% due 1/5/19	$ 250,000	$ 250,000
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	Pilgrim Bank	Certificate of deposit, 2.23% due 11/8/19	250,000	250,000
	Institution for Savings	Certificate of deposit, 2.47%, due 2/9/20	100,000	100,000
	Pilgrim Bank	Certificate of deposit, 2.96% due 2/10/20	150,000	150,000
	Main Street Bank	Certificate of deposit, 2.10% due 5/8/20	250,000	250,000
	Century Bank	Certificate of deposit, 2.47% due 6/8/20	250,000	250,000
	Blue Hills Bank	Certificate of deposit, 2.96% due 1/9/21	100,000	100,000
	Total investments		$ 1,600,000	$ 1,600,000

There were no investment assets which were both acquired and disposed of during the plan year.

See independent auditor's report.

EXPLANATION FOR AMENDED 5500 FILING

The plan administrator has determined that a clerical error was made while gathering the information needed to prepare the plan year 2018 5500 filing. An employer was dropped from the list of participating employers on Schedule D "DFE/Participation Plan Information". The plan administrator has also determined that no information, other schedules nor attachments were affected by this oversight and no employee of the employer was affected by this oversight.

The plan administrator wishes to assure the Department that this oversight was strictly a clerical error and not intentional. All necessary steps and procedures have been taken to assure this type of error will not be repeated.

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 01/01/2018 and ending 12/31/2018

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

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
MASSACHUSETTS BANKERS ASSOCIATION
GROUP INSURANCE TRUST

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 04/01/1953

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)
MASS BANKERS ASSOC GROUP INS TRUST

ONE WASHINGTON MALL

BOSTON MA 02108

2b Employer Identification Number (EIN) 04-2628271

2c Plan Sponsor's telephone number 617-523-7595

2d Business code (see instructions) 524290

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	Chad Pook	08/03/2023	CHAD POOK
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Kathleen Murphy	Aug 3, 2023	KATHLEEN M. MURPHY
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500. **Form 5500 (2022) v. 220413**

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

Application for Extension of Time To File Certain Employee Plan Returns

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

OMB No. 1545-0212

File With IRS Only

Part I Identification

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

MASS BANKERS ASSOC GROUP INS TRUST

Number, street, and room or suite no. (If a P.O. box, see instructions)
ONE WASHINGTON MALL

City or town, state, and ZIP code
BOSTON, MA 02108

B **Filer's identifying number (see instructions)**

Employer identification number (EIN) (9 digits XX-XXXXXXX)
04-2628271

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

C Plan name	Plan number	Plan year ending - MM	DD	YYYY
MASSACHUSETTS BANKERS ASSOCIATION GROUP INSUR	501	12	31	2018

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

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

2 I request an extension of time until 10/15/2019 to file Form 5500 series. See instructions.

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

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

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

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

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

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

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

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

b Enter the payment amount attached ▶ **b**

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

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

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

Signature ▶ **Date** ▶

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**	10,800
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)**	10,100
a (2)	Total number of active participants at the end of the plan year	**6a(2)**	9,001
b	Retired or separated participants receiving benefits	**6b**	600
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	9,601
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 4D 4L

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

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

a Pension Schedules

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

b General Schedules

- **(1)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information - Small Plan)
- **(3)** [X] **A** (Insurance Information) 6
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [X] **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.) ..... [X] 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.) ... [X] 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 000074892481

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2022** **This Form is Open to Public Inspection**

For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan
MASSACHUSETTS BANKERS ASSOCIATION

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MASS BANKERS ASSOC GROUP INS TRUST

D Employer Identification Number (EIN)
04-2628271

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

A.I.G - BUSINESS TRAVEL ACCIDENT

(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
25-0687550	19445	GTP 0009101853	7900	01/01/2018	12/31/2018

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
6,381	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

MASS FINANCIAL SERVICES INS. AGENCY
1 WASHINGTON MALL STE 800
BOSTON MA 02108-2618

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
6,381			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	Fees and other commissions paid (d) Purpose	(e) Organization code

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

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

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

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

b	Balance at the end of the previous year			7b	
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6) Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

m ☒ Other (specify) ▶ ACCIDENTAL DEATH & DISMEMBERMENT

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	42,550
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount		10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2022** **This Form is Open to Public Inspection**

For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan	**B** Three-digit plan number (PN) ▶	
MASSACHUSETTS BANKERS ASSOCIATION		501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
MASS BANKERS ASSOC GROUP INS TRUST		04-2628271

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

BLUE CROSS BLUE SHIELD OF MA-DENTAL

(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
04-1045815	53228	MULTIPLE	8803	01/01/2018	12/31/2018

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	6d	

Specify nature of costs ▶

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

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

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

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

b	Balance at the end of the previous year			7b	
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6) Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9	Experience-rated contracts:			
a	Premiums: (1) Amount received	9a(1)	9,328,505	
	(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)	9,328,505
b	Benefit charges (1) Claims paid	9b(1)	8,437,087	
	(2) Increase (decrease) in claim reserves	9b(2)		
	(3) Incurred claims (add (1) and (2))		9b(3)	8,437,087
	(4) Claims charged		9b(4)	8,631,140
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)	110,076	
	(F) Charges for risks or other contingencies	9c(1)(F)		
	(G) Other retention charges	9c(1)(G)	587,288	
	(H) Total retention		9c(1)(H)	697,364
	(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 ☒ No

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

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2022** **This Form is Open to Public Inspection**

For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan
MASSACHUSETTS BANKERS ASSOCIATION

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MASS BANKERS ASSOC GROUP INS TRUST

D Employer Identification Number (EIN)
04-2628271

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

BLUE CROSS/BLUE SHIELD OF MA - MEDEX

(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	Policy or contract year (g) To
04-1045815	53228	MULTIPLE	597	01/01/2018	12/31/2018

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 (c) Amount	Fees and other commissions paid (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 (c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

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

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

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

b	Balance at the end of the previous year			7b	
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6) Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

m [X] Other (specify) ▶ MEDICARE SUPPLEMENTAL GROUP MEDICAL

9	Experience-rated contracts:			
a	Premiums: (1) Amount received	9a(1)	1,156,814	
	(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) 1,156,814
b	Benefit charges (1) Claims paid	9b(1)	922,075	
	(2) Increase (decrease) in claim reserves	9b(2)		
	(3) Incurred claims (add (1) and (2))			9b(3) 922,075
	(4) Claims charged			9b(4) 937,750
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)	219,064	
	(H) Total retention			9c(1)(H) 219,064
	(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. ▶

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2022** **This Form is Open to Public Inspection**

For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan
MASSACHUSETTS BANKERS ASSOCIATION

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MASS BANKERS ASSOC GROUP INS TRUST

D Employer Identification Number (EIN)
04-2628271

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

BLUE CROSS/BLUE SHIELD-MEDICAL

(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
04-1045815	53228	MULTIPLE	8726	01/01/2018	12/31/2018

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	6d	

Specify nature of costs ▶

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

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

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

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

b	Balance at the end of the previous year		7b	
c	Additions: (1) Contributions deposited during the year	7c(1)		
	(2) Dividends and credits	7c(2)		
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below) ▶	7c(5)		
	(6) Total additions		7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)		7d	
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	7e(2)		
	(3) Transferred to separate account	7e(3)		
	(4) Other (specify below) ▶	7e(4)		
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9	Experience-rated contracts:			
a	Premiums: (1) Amount received	9a(1)	134,743,849	
	(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) 134,743,849
b	Benefit charges (1) Claims paid	9b(1)	120,361,260	
	(2) Increase (decrease) in claim reserves	9b(2)		
	(3) Incurred claims (add (1) and (2))			9b(3) 120,361,260
	(4) Claims charged			9b(4) 122,374,387
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)	280,776	
	(F) Charges for risks or other contingencies	9c(1)(F)		
	(G) Other retention charges	9c(1)(G)	12,088,687	
	(H) Total retention			9c(1)(H) 12,369,463
	(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. ▶

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2022** **This Form is Open to Public Inspection**

For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan
MASSACHUSETTS BANKERS ASSOCIATION

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MASS BANKERS ASSOC GROUP INS TRUST

D Employer Identification Number (EIN)
04-2628271

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

1 Coverage Information:

(a) Name of insurance carrier

THE HARTFORD

(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
06-0838648	70815	MULTIPLE	10753	01/01/2018	12/31/2018

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)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below) ▶	7e(4)			
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

m ☒ Other (specify) ▶ ACCIDENTAL DEATH & DISBURSEMENT

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	1,951,560
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount		10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2022** **This Form is Open to Public Inspection**

For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan	**B** Three-digit plan number (PN) ▶	
MASSACHUSETTS BANKERS ASSOCIATION		501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
MASS BANKERS ASSOC GROUP INS TRUST		04-2628271

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

VISION SERVICE PLAN

(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
06-1227840	39616	MULTIPLE	6357	01/01/2018	12/31/2018

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
76,100	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

MASS FINANCIAL SERVICES INS. AGENCY
1 WASHINGTON MALL STE 800
BOSTON MA 02108-2618

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
76,100			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

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

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

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

b	Balance at the end of the previous year			7b	
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6) Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9	Experience-rated contracts:			
a	Premiums: (1) Amount received	9a(1)	1,271,624	
	(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) 1,271,624
b	Benefit charges (1) Claims paid	9b(1)	1,064,544	
	(2) Increase (decrease) in claim reserves	9b(2)		
	(3) Incurred claims (add (1) and (2))			9b(3) 1,064,544
	(4) Claims charged			9b(4) 1,064,544
c	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions	9c(1)(A)	76,100	
	(B) Administrative service or other fees	9c(1)(B)	216,176	
	(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) 292,276
	(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 ☒ No

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2022** **This Form is Open to Public Inspection.**

For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan	**B** Three-digit plan number (PN) ▶
MASSACHUSETTS BANKERS ASSOCIATION	501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
MASS BANKERS ASSOC GROUP INS TRUST	04-2628271

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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

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

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

MASS FIN SERVICES INS AGENCY 04-2680895

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13	NONE	0.	Yes [X] No [ ]	Yes [X] No [ ]	1,082,546.	Yes [ ] No [X]

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

LIBERTE GROUP LLC 26-2435423

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	17,900.	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

WOLF & COMPANY, P.C. 04-2689883

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	11,958.	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

SCHEDULE D (Form 5500)	DFE/Participating Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	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.	2022 This Form is Open to Public Inspection.

For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan	B Three-digit plan number (PN) ▶	
MASSACHUSETTS BANKERS ASSOCIATION		501
C Plan or DFE sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
MASS BANKERS ASSOC GROUP INS TRUST	04-2628271	

Part I **Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)**
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor ADAMS COMMUNITY BANK	**c** EIN-PN 04-1851620 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor ATHOL SAVINGS BANK	**c** EIN-PN 04-1046670 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor BANK OF CANTON	**c** EIN-PN 04-1148230 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor BELMONT SAVINGS BANK	**c** EIN-PN 04-1078435 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor ONEUNITED BANK	**c** EIN-PN 04-2764211 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor BRIDGEWATER SAVINGS BANK	**c** EIN-PN 04-1118820 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor BRISTOL COUNTY SAVINGS BANK	**c** EIN-PN 04-3317338 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor BROOKLINE BANK	**c** EIN-PN 04-1125010 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor CAPE ANN SAVINGS BANK	**c** EIN-PN 04-1148820 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor THE COOPERATIVE BANK OF CAPE COD	**c** EIN-PN 04-1148930 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor CAPE COD FIVE CENTS SAVINGS BANK	**c** EIN-PN 04-1149070 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor CENTURY BANK	**c** EIN-PN 04-6202762 501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor BAYCOAST BANK	**c** EIN-PN 04-1178460 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor CLINTON SAVINGS BANK	**c** EIN-PN 04-1185690 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor COUNTRY BANK FOR SAVINGS	**c** EIN-PN 04-1946610 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor DEAN BANK	**c** EIN-PN 04-1237280 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor DEDHAM INSTITUTION FOR SAVINGS	**c** EIN-PN 04-1238700 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MARTHA'S VINEYARD SAVINGS BANK	**c** EIN-PN 04-2188463 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor EAST BOSTON SAVINGS BANK	**c** EIN-PN 04-3130808 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor EAST CAMBRIDGE SAVINGS BANK	**c** EIN-PN 04-1269550 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor BANK ESB/EASTHAMPTON SAVINGS BANK	**c** EIN-PN 04-1272090 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor ENTERPRISE BANK & TRUST COMPANY	**c** EIN-PN 04-2993547 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor BANK FIVE	**c** EIN-PN 41-2178171 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor FAMILY FEDERAL SAVINGS BANK	**c** EIN-PN 04-1328570 501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor RADIUS BANK	**c** EIN-PN 04-2960120 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor ROLLSTONE BANK & TRUST	**c** EIN-PN 04-1328870 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MUTUAL ONE BANK	**c** EIN-PN 04-1339820 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor BANKGLOUCESTER	**c** EIN-PN 04-1371820 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor GREENFIELD SAVINGS BANK	**c** EIN-PN 81-0669576 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor HINGHAM INSTITUTION FOR SAVINGS	**c** EIN-PN 04-1442480 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MOUNTAINONE BANK	**c** EIN-PN 04-3413060 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor AVIDIA BANK	**c** EIN-PN 04-3395834 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor COMMONWEALTH CO-OPERATIVE BANK	**c** EIN-PN 04-1465980 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor INSTITUTION FOR SAVINGS NEWBURYPORT	**c** EIN-PN 04-1471660 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor BEVERLY BANK	**c** EIN-PN 04-1087180 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor LEE BANK	**c** EIN-PN 04-3158399 501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor LOWELL FIVE CENT SAVINGS BANK	**c** EIN-PN 45-3131005 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MANSFIELD BANK	**c** EIN-PN 04-1578690 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MARBLEHEAD BANK	**c** EIN-PN 04-1580550 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MAIN STREET BANK	**c** EIN-PN 04-1584100 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MASSACHUSETTS BANKERS ASSOCIATION	**c** EIN-PN 04-1589780 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MECHANICS CO-OPERATIVE BANK	**c** EIN-PN 04-1608620 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor CHARLES RIVER BANK	**c** EIN-PN 04-1609550 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MIDDLESEX FEDERAL SAVINGS, F.A.	**c** EIN-PN 04-1618915 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MIDDLESEX SAVINGS BANK	**c** EIN-PN 27-0402195 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MILFORD FEDERAL BANK	**c** EIN-PN 04-1620675 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MILFORD NATIONAL BANK	**c** EIN-PN 04-1620797 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MILLBURY NATIONAL BANK	**c** EIN-PN 04-1621330 501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MILLBURY SAVINGS BANK	**c** EIN-PN 04-1621370 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MONSON SAVINGS BANK	**c** EIN-PN 56-2545442 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor PATRIOT COMMUNITY BANK	**c** EIN-PN 20-3411700 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor NATIONAL GRAND BANK OF MARBLEHEAD	**c** EIN-PN 04-2832782 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor NEEDHAM BANK	**c** EIN-PN 04-1655620 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor NEWBURYPORT FIVE CENTS SAVINGS BANK	**c** EIN-PN 04-1669070 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor NEW ENGLAND AUTOMATED CLEARING HOUSE	**c** EIN-PN 04-2514013 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor NORTH BROOKFIELD SAVINGS BANK	**c** EIN-PN 04-1677290 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor NORTH CAMBRIDGE CO-OPERATIVE BANK	**c** EIN-PN 04-1677300 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor NORTH EASTON SAVINGS BANK	**c** EIN-PN 04-1677530 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor NORTHEAST RETIREMENT SERVICES	**c** EIN-PN 04-2686260 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor NORTH MIDDLESEX SAVINGS BANK	**c** EIN-PN 04-1678010 501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor NORTH SHORE BANK	**c** EIN-PN 04-3414678 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor NORWOOD BANK	**c** EIN-PN 04-1680920 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor PENTUCKET BANK	**c** EIN-PN 04-1715580 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor PEOPLES SAVINGS BANK, HOLYOKE	**c** EIN-PN 04-1716200 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor PILGRIM BANK	**c** EIN-PN 04-1728400 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor PROVIDENT BANK	**c** EIN-PN 04-1746360 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor ENVISION BANK	**c** EIN-PN 74-3073286 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor THE SAVINGS BANK	**c** EIN-PN 04-1939290 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor SEAMEN'S BANK	**c** EIN-PN 04-1817540 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor S-BANK	**c** EIN-PN 04-1852680 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor STOUGHTON COOPERATIVE BANK	**c** EIN-PN 04-1875980 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor WAKEFIELD COOPERATIVE BANK	**c** EIN-PN 04-1939190 501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor WALPOLE CO-OPERATIVE BANK	**c** EIN-PN 04-1943030 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor WASHINGTON SAVINGS BANK	**c** EIN-PN 04-1949430 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor WATERTOWN SAVINGS BANK	**c** EIN-PN 04-1950840 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor WEBSTER FIVE CENTS SAVINGS BANK	**c** EIN-PN 04-1953630 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor WESTFIELD BANK	**c** EIN-PN 04-3305700 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor WINCHESTER CO-OPERATIVE BANK	**c** EIN-PN 04-1978070 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor WINCHESTER SAVINGS BANK	**c** EIN-PN 04-1978230 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor WINTER HILL BANK	**c** EIN-PN 04-1980523 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor WRENTHAM CO-OPERATIVE BANK	**c** EIN-PN 04-1991475 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor BANK OF EASTON	**c** EIN-PN 04-1677520 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor CANTON COOPERATIVE BANK	**c** EIN-PN 04-1207730 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor COLONIAL COOPERATIVE BANK	**c** EIN-PN 04-1166100 501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor COLONIAL FEDERAL SAVINGS BANK	**c** EIN-PN 04-1983105 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor COOPERATIVE BANK EMP RET ASSOC	**c** EIN-PN 04-6035593 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor DEPOSITORS INSURANCE FUND	**c** EIN-PN 04-1647690 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor EQUITABLE COOPERATIVE BANK	**c** EIN-PN 04-1290470 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor EVERETT COOPERATIVE BANK	**c** EIN-PN 04-1294820 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor FLORENCE SAVINGS BANK	**c** EIN-PN 04-1332530 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor FOXBOROUGH FEDERAL SAVINGS BANK	**c** EIN-PN 04-1339492 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor HAVERHILL BANK	**c** EIN-PN 04-1426920 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MASS. BUSINESS DEVELOPMENT	**c** EIN-PN 04-2163213 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor METHUEN COOPERATIVE BANK	**c** EIN-PN 04-0615835 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor MUTUAL BANK	**c** EIN-PN 04-1647485 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor ABINGTON BANK	**c** EIN-PN 04-1676630 501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor SAVERS BANK	**c** EIN-PN 04-1853350 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor SAVINGS BANK LIFE INSURANCE COUNCIL	**c** EIN-PN 04-3117253 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor WELLESLEY BANK	**c** EIN-PN 04-1956610 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor GREENFIELD CO-OPERATIVE BANK	**c** EIN-PN 04-1400390 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor LEADER BANK	**c** EIN-PN 04-3557920 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor HARBOR ONE	**c** EIN-PN 04-1123040 501
a	Plan name MASS BANKER ASSOC GROUP INS TRUST	
b	Name of plan sponsor CAMBRIDGE SAVINGS BANK	**c** EIN-PN 04-1145100 501
a	Plan name	
b	Name of plan sponsor	**c** EIN-PN
a	Plan name	
b	Name of plan sponsor	**c** EIN-PN
a	Plan name	
b	Name of plan sponsor	**c** EIN-PN
a	Plan name	
b	Name of plan sponsor	**c** EIN-PN
a	Plan name	
b	Name of plan sponsor	**c** EIN-PN

SCHEDULE H (Form 5500)	Financial Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	2022 This Form is Open to Public Inspection

For calendar plan year 2022 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan

MASSACHUSETTS BANKERS ASSOCIATION

B Three-digit plan number (PN) ▶ 501

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

MASS BANKERS ASSOC GROUP INS TRUST

D Employer Identification Number (EIN)

04-2628271

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other SEE STATEMENT 1	1b(3)	18,314	27,367
c General investments:			
(1) Interest-bearing cash (incl. money market accounts & certificates of deposit)	1c(1)	2,595,072	4,558,069
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance co. general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

			(a) Beginning of Year	(b) End of Year
1 d	Employer-related investments:			
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
e	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	2,613,386	4,585,436
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h	0	2,600
i	Acquisition indebtedness	1i		
j	Other liabilities SEE STATEMENT 2	1j	32,182	139,907
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	32,182	142,507
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	2,581,204	4,442,929

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

	Income		(a) Amount	(b) Total
a	**Contributions:**			
	(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	42,537	
	(B) Participants	2a(1)(B)		
	(C) Others (including rollovers)	2a(1)(C)		
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		42,537
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	34,995	
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	(F) Other	2b(1)(F)		
	(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		34,995
	(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)		
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
	(D) Total dividends. Add lines **2b(2)(A), (B),** and **(C)**	2b(2)(D)		
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		
	(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)		
	(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		

			(a) Amount	(b) Total
(6)	Net investment gain (loss) from common/collective trusts	2b(6)		
(7)	Net investment gain (loss) from pooled separate accounts	2b(7)		
(8)	Net investment gain (loss) from master trust investment accounts	2b(8)		
(9)	Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10)	Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c	Other income SEE STATEMENT 3	2c		2,430,135
d	Total income. Add all **income** amounts in column (b) and enter total	2d		2,507,667
	Expenses			
e	Benefit payment and payments to provide benefits:			
(1)	Directly to participants or beneficiaries, including direct rollovers	2e(1)		
(2)	To insurance carriers for the provision of benefits	2e(2)	36,157	
(3)	Other	2e(3)		
(4)	Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		36,157
f	Corrective distributions (see instructions)	2f		
g	Certain deemed distributions of participant loans (see instructions)	2g		
h	Interest expense	2h		
i	Administrative expenses: (1) Professional fees	2i(1)	31,957	
(2)	Contract administrator fees	2i(2)	566,041	
(3)	Investment advisory and management fees	2i(3)		
(4)	Other SEE STATEMENT 4	2i(4)	11,787	
(5)	Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		609,785
j	Total expenses. Add all **expense** amounts in column (b) and enter total	2j		645,942
	Net Income and Reconciliation			
k	Net income (loss). Subtract line **2j** from line **2d**	2k		1,861,725
l	Transfers of assets:			
(1)	To this plan	2l(1)		
(2)	From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):
(1) [X] Unmodified **(2)** [ ] Qualified **(3)** [ ] Disclaimer **(4)** [ ] Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.
(1) [ ] DOL Regulation 2520.103-8 **(2)** [ ] DOL Regulation 2520.103-12(d) **(3)** [ ] neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:
(1) Name: WOLF & COMPANY, P.C. **(2)** EIN: 04-2689883

d The opinion of an independent qualified public accountant is **not attached** because:
(1) [ ] This form is filed for a CCT, PSA, or MTIA. **(2)** [ ] It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.

During the plan year:

			Yes	No	Amount
a	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a			

			Yes	No	Amount
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e			
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f			
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g			
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h			
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j	X		
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k			
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m			
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? ☐ Yes ☐ No

If "Yes," enter the amount of any plan assets that reverted to the employer this year .

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ☐ Yes ☐ No ☐ Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

SCHEDULE H — OTHER RECEIVABLES — STATEMENT 1

DESCRIPTION	BEGINNING	ENDING
OTHER RECEIVABLES	14,714.	27,367.
PREPAID INCOME TAXES	3,600.	0.
TOTAL TO SCHEDULE H, LINE 1B(3)	18,314.	27,367.

SCHEDULE H — OTHER PLAN LIABILITIES — STATEMENT 2

DESCRIPTION	BEGINNING	ENDING
UNEARNED PREMIUM INCOME	32,182.	0.
INCOME TAX PAYABLE	0.	4,900.
DUE TO AFFILIATE	0.	135,007.
TOTAL TO SCHEDULE H, LINE 1J	32,182.	139,907.

SCHEDULE H — OTHER INCOME — STATEMENT 3

DESCRIPTION	AMOUNT
RISK SHARING ARRANGEMENT	2,415,254.
PERFORMANCE GUARANTEES	14,314.
OTHER INCOME	567.
TOTAL TO SCHEDULE H, LINE 2C	2,430,135.

SCHEDULE H — OTHER ADMINISTRATIVE EXPENSES — STATEMENT 4

DESCRIPTION	AMOUNT
INCOME TAXES	11,787.
TOTAL TO SCHEDULE H, LINE 2I(4)	11,787.

Massachusetts Bankers Association Group Insurance Trust

Schedule H, Line 4i - Schedule of Assets (Held at End of Year)

E.I.N. 04-2628271 Plan Number 501

December 31, 2018

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or maturity	(d) Cost	(e) Current Value
	Needham Bank	Certificate of deposit, 1.29% due 1/5/19	$ 250,000	$ 250,000
	Cornerstone Bank	Certificate of deposit, 1.65% due 9/17/19	100,000	100,000
	Institution for Savings	Certificate of deposit, 2.23% due 10/21/19	150,000	150,000
	Pilgrim Bank	Certificate of deposit, 2.23% due 11/8/19	250,000	250,000
	Institution for Savings	Certificate of deposit, 2.47%, due 2/9/20	100,000	100,000
	Pilgrim Bank	Certificate of deposit, 2.96% due 2/10/20	150,000	150,000
	Main Street Bank	Certificate of deposit, 2.10% due 5/8/20	250,000	250,000
	Century Bank	Certificate of deposit, 2.47% due 6/8/20	250,000	250,000
	Blue Hills Bank	Certificate of deposit, 2.96% due 1/9/21	100,000	100,000
	Total investments		$ 1,600,000	$ 1,600,000

There were no investment assets which were both acquired and disposed of during the plan year.

See independent auditor's report.

Massachusetts Bankers Association Group Insurance Trust

Schedule H, Line 4j - Schedule of Reportable Transactions

E.I.N. 04-2628271 Plan Number 501

Year Ended December 31, 2018

(a) Identity of party involved	(b) Description of asset (include interest rate and maturity in case of a loan)	(c) Purchase price	(d) Selling price	(e) Lease rental	(f) Expense incurred with transaction	(g) Cost of asset	(h) Current value of asset on transaction date	(i) Net gain or (loss)
Category (1) - A single transaction in excess of 5% of plan assets:								
Institution for Savings	-Maturity of CD, 1.00%, due 2/21/18	$ -	$ 150,000	$ -	$ -	$ 150,000	$ 150,000	$ -
Institution for Savings	-Maturity of CD, 1.00%, due 6/9/18	-	250,000	-	-	250,000	250,000	-
Pilgrim Bank	-Maturity of CD, 1.48%, due 8/8/18	-	250,000	-	-	250,000	250,000	-
Main Street Bank	-Maturity of CD, 1.25%, due 11/8/18	-	250,000	-	-	250,000	250,000	-
Century Bank	-Maturity of CD, 1.74%, due 12/8/18	-	250,000	-	-	250,000	250,000	-
Institution for Savings	-Purchase of CD, 2.23%, due 10/21/19	150,000	-	-	-	150,000	150,000	-
Pilgrim Bank	-Purchase of CD, 2.23%, due 11/8/19	250,000	-	-	-	250,000	250,000	-
Pilgrim Bank	-Purchase of CD, 2.96%, due 2/10/20	150,000	-	-	-	150,000	150,000	-
Main Street Bank	-Purchase of CD, 2.10%, due 5/8/20	250,000	-	-	-	250,000	250,000	-
Century Bank	-Purchase of CD, 2.47%, due 6/8/20	250,000	-	-	-	250,000	250,000	-
Category (2) - A series of transactions with the same person involving property other than securities and aggregating to more than 5% of plan assets:								
None								
Category (3) - A series of securities transactions in excess of 5% of plan assets:								
Institution for Savings	-Maturity of CD, 1.00%, due 2/21/18	$ -	$ 150,000	$ -	$ -	$ 150,000	$ 150,000	$ -
Institution for Savings	-Maturity of CD, 1.00%, due 6/9/18	-	250,000	-	-	250,000	250,000	-
Pilgrim Bank	-Maturity of CD, 1.48%, due 8/8/18	-	250,000	-	-	250,000	250,000	-
Main Street Bank	-Maturity of CD, 1.25%, due 11/8/18	-	250,000	-	-	250,000	250,000	-
Century Bank	-Maturity of CD, 1.74%, due 12/8/18	-	250,000	-	-	250,000	250,000	-
Institution for Savings	-Purchase of CD, 2.23%, due 10/21/19	150,000	-	-	-	150,000	150,000	-
Pilgrim Bank	-Purchase of CD, 2.23%, due 11/8/19	250,000	-	-	-	250,000	250,000	-
Pilgrim Bank	-Purchase of CD, 2.96%, due 2/10/20	150,000	-	-	-	150,000	150,000	-
Main Street Bank	-Purchase of CD, 2.10%, due 5/8/20	250,000	-	-	-	250,000	250,000	-
Century Bank	-Purchase of CD, 2.47%, due 6/8/20	250,000	-	-	-	250,000	250,000	-
Category (4) - A single transaction with the same person in excess of 5% of plan assets.								
None								

See independent auditor's report.

Efast2 Authorization to File Form 5500 Electronically

Plan Sponsor: Massachusetts Bankers Association Group Insurance Trust

Plan Number: 501

Plan Year-end: 12/31/2018

I/We the undersigned authorize Wolf & Company, P.C. to file amended Form 5500 Annual Return/ Report of Employee Benefit Plan for year ended 12/31/2018 for the Massachusetts Bankers Association Group Insurance Trust. Further, I/We authorize Wolf & Company, P.C. to enter their ID and PIN number as assigned by Efast2.

I/we have also provided to Wolf & Company, P.C. a signed copy of Form 5500 to be attached to the efile.

Signatures

Chad Pook
_____

Plan Administrator

Date 08/03/2023

Kathleen Murphy
_____

Plan Sponsor

Date Aug 3, 2023

Massachusetts Bankers Association Group Insurance Trust

Schedule H, Line 4j - Schedule of Reportable Transactions

E.I.N. 04-2628271 Plan Number 501

Year Ended December 31, 2018

(a) Identity of party involved	(b) Description of asset (include interest rate and maturity in case of a loan)	(c) Purchase price	(d) Selling price	(e) Lease rental	(f) Expense incurred with transaction	(g) Cost of asset	(h) Current value of asset on transaction date	(i) Net gain or (loss)
Category (1) - A single transaction in excess of 5% of plan assets:								
Institution for Savings	-Maturity of CD, 1.00%, due 2/21/18	$ -	$ 150,000	$ -	$ -	$ 150,000	$ 150,000	$ -
Institution for Savings	-Maturity of CD, 1.00%, due 6/9/18	-	250,000	-	-	250,000	250,000	-
Pilgrim Bank	-Maturity of CD, 1.48%, due 8/8/18	-	250,000	-	-	250,000	250,000	-
Main Street Bank	-Maturity of CD, 1.25%, due 11/8/18	-	250,000	-	-	250,000	250,000	-
Century Bank	-Maturity of CD, 1.74%, due 12/8/18	-	250,000	-	-	250,000	250,000	-
Institution for Savings	-Purchase of CD, 2.23%, due 10/21/19	150,000	-	-	-	150,000	150,000	-
Pilgrim Bank	-Purchase of CD, 2.23%, due 11/8/19	250,000	-	-	-	250,000	250,000	-
Pilgrim Bank	-Purchase of CD, 2.96%, due 2/10/20	150,000	-	-	-	150,000	150,000	-
Main Street Bank	-Purchase of CD, 2.10%, due 5/8/20	250,000	-	-	-	250,000	250,000	-
Century Bank	-Purchase of CD, 2.47%, due 6/8/20	250,000	-	-	-	250,000	250,000	-
Category (2) - A series of transactions with the same person involving property other than securities and aggregating to more than 5% of plan assets:								
None								
Category (3) - A series of securities transactions in excess of 5% of plan assets:								
Institution for Savings	-Maturity of CD, 1.00%, due 2/21/18	$ -	$ 150,000	$ -	$ -	$ 150,000	$ 150,000	$ -
Institution for Savings	-Maturity of CD, 1.00%, due 6/9/18	-	250,000	-	-	250,000	250,000	-
Pilgrim Bank	-Maturity of CD, 1.48%, due 8/8/18	-	250,000	-	-	250,000	250,000	-
Main Street Bank	-Maturity of CD, 1.25%, due 11/8/18	-	250,000	-	-	250,000	250,000	-
Century Bank	-Maturity of CD, 1.74%, due 12/8/18	-	250,000	-	-	250,000	250,000	-
Institution for Savings	-Purchase of CD, 2.23%, due 10/21/19	150,000	-	-	-	150,000	150,000	-
Pilgrim Bank	-Purchase of CD, 2.23%, due 11/8/19	250,000	-	-	-	250,000	250,000	-
Pilgrim Bank	-Purchase of CD, 2.96%, due 2/10/20	150,000	-	-	-	150,000	150,000	-
Main Street Bank	-Purchase of CD, 2.10%, due 5/8/20	250,000	-	-	-	250,000	250,000	-
Century Bank	-Purchase of CD, 2.47%, due 6/8/20	250,000	-	-	-	250,000	250,000	-
Category (4) - A single transaction with the same person in excess of 5% of plan assets.								
None								

See independent auditor's report.