



<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN  <b>3c</b> Administrator's telephone number
<b>4</b> 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: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b> 204
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).  <b>6a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>6a(2)</b> Total number of active participants at the end of the plan year .....  <b>b</b> Retired or separated participants receiving benefits ..... <b>c</b> Other retired or separated participants entitled to future benefits..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....  <b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....  <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b> 204 <b>6a(2)</b> 186 <b>6b</b> 1 <b>6c</b> 0 <b>6d</b> 187 <b>6e</b> <b>6f</b> 187 <b>6g</b> <b>6h</b>
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>
<b>8a</b> If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:  <b>b</b> If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4F 4H 4Q	
<b>9a</b> Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	<b>9b</b> Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
<b>10</b> Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
<b>a Pension Schedules</b> (1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information)  (2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary  (3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	<b>b General Schedules</b> (1) <input type="checkbox"/> <b>H</b> (Financial Information) (2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> <b>2</b> <b>A</b> (Insurance Information) (4) <input type="checkbox"/> <b>C</b> (Service Provider Information) (5) <input type="checkbox"/> <b>D</b> (DFE/Participating Plan Information) (6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)

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

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

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

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

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**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 \_\_\_\_\_

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<p style="text-align: center;"><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p style="text-align: center; font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="text-align: center; font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: large;"><b>2022</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2022 or fiscal plan year beginning **04/01/2022** and ending **03/31/2023**

<p><b>A</b> Name of plan <b>O'KELLEY &amp; SOROHAN ATTORNEYS AT LAW, LLC EMPLOYEES BENEFIT PLAN</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>O'KELLEY &amp; SOROHAN ATTORNEYS AT LAW LLC</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>58-2577994</b></p>	

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**CIGNA HEALTH AND LIFE INSURANCE COMPANY**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
59-1031071	67369	00622436	151	01/01/2022	12/31/2022

**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.

<b>(a)</b> Total amount of commissions paid	<b>(b)</b> Total amount of fees paid
52514	

**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

**CHASTAIN & ASSOCIATES** **PO BOX 1908**  
**ATHENS, GA 30603**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
52514	0		3

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

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

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

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

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

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

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

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

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

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

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

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

**Part II Investment and Annuity Contract Information**  
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

**b** Premiums paid to carrier ..... **6b**

**c** Premiums due but unpaid at the end of the year ..... **6c**

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... **6d**  
 Specify nature of costs ▶

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

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

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

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

**b** Balance at the end of the previous year ..... **7b**

**c** Additions: (1) Contributions deposited during the year ..... **7c(1)**  
 (2) Dividends and credits..... **7c(2)**  
 (3) Interest credited during the year..... **7c(3)**  
 (4) Transferred from separate account..... **7c(4)**  
 (5) Other (specify below) ..... **7c(5)**  
 ▶

(6) Total additions..... **7c(6)**

**d** Total of balance and additions (add lines **7b** and **7c(6)**) ..... **7d**

**e** Deductions:  
 (1) Disbursed from fund to pay benefits or purchase annuities during year ..... **7e(1)**  
 (2) Administration charge made by carrier..... **7e(2)**  
 (3) Transferred to separate account..... **7e(3)**  
 (4) Other (specify below) ..... **7e(4)**  
 ▶

(5) Total deductions..... **7e(5)**

**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**) ..... **7f**

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

- 8** Benefit and contract type (check all applicable boxes)
- a**  Health (other than dental or vision)
  - b**  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:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>	
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>	
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>	
	(4) Earned ((1) + (2) - (3)) .....		<b>9a(4)</b>
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>	
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>	
	(3) Incurred claims (add (1) and (2)) .....		<b>9b(3)</b>
	(4) Claims charged .....		<b>9b(4)</b>
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions .....	<b>9c(1)(A)</b>	443520
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>	51800
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>	
	(D) Other expenses .....	<b>9c(1)(D)</b>	
	(E) Taxes .....	<b>9c(1)(E)</b>	
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>	
	(G) Other retention charges .....	<b>9c(1)(G)</b>	
	(H) Total retention .....	<b>9c(1)(H)</b>	495320
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....	<b>9c(2)</b>	
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....	<b>9d(1)</b>	
	(2) Claim reserves .....	<b>9d(2)</b>	
	(3) Other reserves .....	<b>9d(3)</b>	
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....	<b>9e</b>	
<b>10</b>	Nonexperience-rated contracts:		
<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	
<b>b</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. ....	<b>10b</b>	

**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.**

▶ 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 **04/01/2022** and ending **03/31/2023**

<b>A</b> Name of plan O'KELLEY & SOROHAN ATTORNEYS AT LAW, LLC EMPLOYEES BENEFIT PLAN	<b>B</b> Three-digit plan number (PN) ▶ 501
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 O'KELLEY & SOROHAN ATTORNEYS AT LAW LLC	<b>D</b> Employer Identification Number (EIN) 58-2577994

**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  
PRINCIPAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
42-0127290	61271	1139464	282	04/01/2022	03/31/2023

**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 11596	(b) Total amount of fees paid 369
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**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

THE CASON GROUP INC  
1612 MARION ST  
COLUMBIA, SC 29201-2939

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
9115	369	BONUS	3

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

CHASTAIN & ASSOC INS AGCY  
PO BOX 1908  
ATHENS, GA 30603-1908

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2481			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	

<b>Part II</b>	<b>Investment and Annuity Contract Information</b>	
	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.	
<b>4</b>	Current value of plan's interest under this contract in the general account at year end.....	<b>4</b>
<b>5</b>	Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>
<b>6</b>	Contracts With Allocated Funds:	
<b>a</b>	State the basis of premium rates ▶	
<b>b</b>	Premiums paid to carrier .....	<b>6b</b>
<b>c</b>	Premiums due but unpaid at the end of the year .....	<b>6c</b>
<b>d</b>	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 ▶	<b>6d</b>
<b>e</b>	Type of contract: (1) <input type="checkbox"/> individual policies                      (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
<b>f</b>	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
<b>7</b>	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
<b>a</b>	Type of contract: (1) <input type="checkbox"/> deposit administration                      (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment                      (4) <input type="checkbox"/> other ▶	
<b>b</b>	Balance at the end of the previous year .....	<b>7b</b>
<b>c</b>	Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>
	(2) Dividends and credits.....	<b>7c(2)</b>
	(3) Interest credited during the year.....	<b>7c(3)</b>
	(4) Transferred from separate account.....	<b>7c(4)</b>
	(5) Other (specify below) .....	<b>7c(5)</b>
	▶	
	(6) Total additions.....	<b>7c(6)</b>
<b>d</b>	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>
<b>e</b>	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>
	(2) Administration charge made by carrier.....	<b>7e(2)</b>
	(3) Transferred to separate account.....	<b>7e(3)</b>
	(4) Other (specify below) .....	<b>7e(4)</b>
	▶	
	(5) Total deductions.....	<b>7e(5)</b>
<b>f</b>	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....	<b>7f</b>

**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) ▶

**9** Experience-rated contracts:

<b>a</b> Premiums: (1) Amount received .....	<b>9a(1)</b>			
(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>			
(3) Increase (decrease) in unearned premium reserve.....	<b>9a(3)</b>			
(4) Earned ((1) + (2) - (3)).....			<b>9a(4)</b>	
<b>b</b> Benefit charges (1) Claims paid.....	<b>9b(1)</b>			
(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>			
(3) Incurred claims (add (1) and (2)).....			<b>9b(3)</b>	
(4) Claims charged .....			<b>9b(4)</b>	
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions .....	<b>9c(1)(A)</b>			
(B) Administrative service or other fees .....	<b>9c(1)(B)</b>			
(C) Other specific acquisition costs.....	<b>9c(1)(C)</b>			
(D) Other expenses .....	<b>9c(1)(D)</b>			
(E) Taxes .....	<b>9c(1)(E)</b>			
(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>			
(G) Other retention charges.....	<b>9c(1)(G)</b>			
(H) Total retention.....			<b>9c(1)(H)</b>	
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....			<b>9c(2)</b>	
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....			<b>9d(1)</b>	
(2) Claim reserves .....			<b>9d(2)</b>	
(3) Other reserves .....			<b>9d(3)</b>	
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....			<b>9e</b>	

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	177728
<b>b</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.	<b>10b</b>	

**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. ▶



O'Kelley & Sorohan, Attorneys at La  
Rebecca G Austin  
2170 Satellite Blvd NW  
#375  
Duluth GA 30097

Dear Employer:

Enclosed is the information you may need to complete and file Form 5500 with the Internal Revenue Service (IRS). Plans that are required to file the 5500 series forms must do so within a specified time period following the end of their plan year.

The Form 5500 series filing requirements are highly technical. It is your responsibility as plan sponsor to determine with your tax or legal advisor whether and when your plan is required to file a Form 5500 and any of the attendant schedules.

The information we provide for your use in preparing Schedule A and/or Schedule C of Form 5500 reflects premiums or compensation received and posted during the timeframes noted and may be adjusted in the future.

The amounts reported may not reconcile with your accounting due to timing.

Compensation for Service and / or General Agent Agreements are reflected on Schedule A and C reporting but may not have been directly paid to the producer by the Plan. Please note that even though these additional payments are associated with your plan for reporting purposes, the expenses associated with the payments may not impact your specific case level rates and premiums.

If you have any questions regarding the information provided, please contact Cigna at [SelectUnderwritingOperationsSupport@Cigna.com](mailto:SelectUnderwritingOperationsSupport@Cigna.com). For questions regarding the preparation of the Form 5500 consult your tax or legal advisor.

Sincerely,  
Cigna

"Cigna" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

Sys 2/18/2023

# Cigna

## INFORMATION FOR COMPLETING SCHEDULE A ON THE IRS FORM 5500

This is NOT an official form. The information provided on this form is to assist you in completing the official Schedule A, as required under the Employee Retirement Income Security Act of 1974 (ERISA). Refer to the IRS Form 5500 and Instructions for more information on filing your IRS Form 5500. The information reflected in this report is accurate and complete based upon information available to Cigna Companies at the time this report is prepared and is certified as being complete and accurate.

**For Plan Year Beginning:** January 01, 2022 **and Ending:** December 31, 2022

**Name of Plan:** O'Kelley & Sorohan, Attorneys at La

### SCHEDULE A - INSURANCE INFORMATION:

#### Information Concerning Insurance Contract Coverage, Fees and Commissions

Name of Insurance Carrier: Cigna Health and Life Insurance Company

EIN number	NAIC code	Contract or identification number	Policy or contract year:	
			From	To
59-1031071	67369	00622436	1/1/2022	12/31/2022

Approximate number of persons covered at end of policy or contract year:

**Benefit**      **Employee**      **Dependent**      **Spouse**      **Family**      **Child**

Insurance fees, benefit advisor fees and commissions paid to agents, brokers, and other persons:

Represents the amount of commission paid during the contract year. This amount is reflective of payments made during the contract year that may be attributable to multiple contract years.

In addition to the commissions and fees reported, Cigna enters into compensation programs under which certain agents and brokers provide our companies with market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific policies, is funded from our general overhead, and is not required to be reported on Schedule A. Your agent or broker may also have participated, at our expense, in events we sponsor to inform them on our products and services. Contact your agent / broker for specific information about their participation.

Name and address of the agents, brokers or other persons to whom commissions or fees were paid	Amount of commissions paid	Service/Gen. Agent Fees	Benefit Advisor Fees
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Incentive Compensation Payments based on membership in your plan/or lump sum amount:

Producer      Amount

Incentive Compensation Payments are funded by the insurer. Contact your agent, broker or consultant for details.

Total premiums\* or subscription charges paid to carrier: \$443,519.58

State Continuation includes payments made by continuants in amount of \$0.00 administered by CHLIC and applicable to your account.

The premium reported does not reflect the rebates, if any, under the Patient Protection and Affordable Care Act that may have been paid for any prior plan year. Includes charges related to Employee Assistance Plan (i.e. administration fee/insurance premium /commissions) where applicable.

\*Premium may reflect amounts paid for surcharges on provider charges or other assessments imposed under applicable state law.

# Cigna

## INFORMATION FOR COMPLETING SCHEDULE C ON THE IRS FORM 5500

*This is NOT an official form. The information provided on this form is to assist you in completing the official Schedule C, as required under the Employee Retirement Income Security Act of 1974 (ERISA). Refer to the IRS Form 5500 and Instructions for more information on filing your IRS Form 5500. The information reflected in this report is accurate and complete based upon information available to Cigna Companies at the time this report is prepared and is certified as being complete and accurate.*

**For Plan Year Beginning:** **January 01, 2022** **and Ending:** **December 31, 2022**  
**Name of Plan:** **O'Kelley & Sorohan, Attorneys at La**

### SCHEDULE C - SERVICE PROVIDER INFORMATION:

Service Provider	EIN#	Administration fees paid to the service provider *
Cigna Health and Life Insurance Company	59-1031071	\$53,903.86

The following amounts were paid to your broker(s) and/or consultant(s) during the plan year:

**Commissions:** \$52,513.56

**Service / Gen. Agent Fees:** \$0.00

**Incentive Compensation Payments based on membership in your plan/or lump sum amount:** \$0.00

**Incentive Compensation Payments are funded by the Service Provider. Contact your broker(s)/consultant(s) for details.**

\*This amount includes administrative service fees for reporting period and other fees paid by the plan, known as "Direct Compensation" as applicable.

If you have a CHLIC administered HRA and/or HSA, the Administrative Service Fees include fees charged by the bank vendor. Includes charges related to Employee Assistance Plan (i.e. administration fee/insurance premium/commissions) where applicable.

**Direct Compensation\*\* for calendar year 2022 :** \$22,617.85

\*\*Direct compensation amount does not include compensation received by Express Scripts, Inc. for pharmacy benefit management and related services under direct contracts with you. Express Scripts, Inc. separately reports this information to you for Schedule C reporting.

Direct compensation amount does not include the following compensation received, if any, by affiliated companies:

- Plan benefit payments, if any, made to eviCore
- Utilization management fees paid to eviCore
- Plan benefit payment made to Evernorth Care Solutions, Inc. or Evernorth Behavioral Health, Inc.
- Plan benefit payments made to Cigna HealthCare of Arizona, Inc.(Cigna Medical Group)

The amount of such compensation, if any, with respect to your plan is available upon request.

The Service Provider may have received indirect compensation and eligible indirect compensation associated with your plan. Sources of indirect compensation and eligible indirect compensation will follow if applicable.

Indirect compensation reported does not include any plan participant cost-sharing payments made to the following affiliated companies:

- eviCore
- Evernorth Care Solutions, Inc.
- Evernorth Behavioral Health, Inc.
- Cigna HealthCare of Arizona, Inc. (Cigna Medical Group)



# Cigna

## Plan Detail Report

The following information will assist you in completing the Schedule A with respect to your Cigna insurance policy.

For Plan Year Beginning: January 01, 2022

and Ending: December 31, 2022

Name of Plan: O'Kelley & Sorohan, Attorneys at La

Plan #: 00622436

### PREMIUMS PLAN DETAIL

<u>BENEFIT</u>	<u>PREMIUMS</u>	<u>ADMIN FEES*</u>	<u>TERMINATION PREMIUM</u>	<u>TERMINATION FEES</u>	<u>STATE CONTINUATION FEES</u>	<u>TOTAL PAID</u>
DISCRETN	\$0.00	(\$32,000.00)	\$0.00	\$0.00	\$0.00	(\$32,000.00)
MEDICAL	\$443,519.58	\$83,799.57	\$0.00	\$0.00	\$0.00	\$527,319.15
<b>TOTALS</b>	<b>\$443,519.58</b>	<b>\$51,799.57</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$495,319.15</b>

### COMMISSIONS PAID DETAIL

<u>BENEFIT</u>	<u>TOTAL COMM PAID</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
MEDICAL	\$52,513.56	515608	CHASTAIN AND ASSOCIATES
<b>TOTAL</b>	<b>\$52,513.56</b>		

### BENEFIT ADVISOR FEE PAID DETAIL

<u>BENEFIT</u>	<u>TOTAL FEES</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
<b>TOTAL</b>			

### SERVICE AND / OR GENERAL AGENT FEE PAID DETAIL

<u>BENEFIT</u>	<u>TOTAL FEES</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
<b>TOTAL</b>			

### INCENTIVE COMPENSATION PAYMENTS BASED ON MEMBERSHIP IN YOUR PLAN/OR LUMP SUM AMOUNT

<u>TOTAL PAID</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
<b>TOTAL</b>		

### EXPOSURES DETAIL (Last Month of the Plan Period)

<u>BENEFIT</u>	<u>EMPLOYEE</u>	<u>DEPENDENT</u>	<u>SPOUSE</u>	<u>FAMILY</u>	<u>CHILD</u>
MEDICAL	121	0	8	14	8

\*Admin Fees Include Commissions

Sys 2/18/2023

Cindi Cochran  
Ops Support Analyst  
1-800-986-3343 Ext. 57111  
cochran.cynthia@principal.com

SBD Support Operations  
Principal Life Insurance Company  
711 High Street  
Des Moines, IA 50392-5060



April 17, 2023

O'KELLEY & SOROHAN  
ATTORNEYS AT LAW LLC  
ATTN REBECCA AUSTIN  
2170 SATELLITE BLVD STE 375  
DULUTH GA 30097

THE CASON GROUP INC  
1612 MARION ST  
COLUMBIA SC 29201-2939

Re Acct No. 1139464

Anniversary Date: April 1, 2023

We thank you for selecting Principal for your insurance needs.

As you are likely aware, most insured welfare benefit plans that are subject to the Employee Retirement Income Security Act (ERISA), and that cover 100 or more employee plan participants at the beginning of their plan year, are required to file Form 5500 with the Employee Benefits Security Administration of the U.S. Department of Labor. The Schedule A must be attached to the Form 5500 filing if any of the benefits under the plan are provided by an insurance company.

We've enclosed your Schedule A Insurance Information **worksheet** for the period April 1, 2022 through March 31, 2023 to assist you with your filing of the Schedule A (Form 5500). The paid premium reported on the Schedule A worksheet represents premium received and applied to your account during the reported period. This information will need to be transferred to a Schedule A template.

If you have questions about the applicability of these requirements to your plan, please consult with your legal or tax advisor. For filing assistance and additional information:

Contact the Employee Benefits Security Administration, an agency within the U.S. Department of Labor, at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

The Department of Labor requires filings to be submitted electronically at [www.efast.dol.gov](http://www.efast.dol.gov).

Additional help with EFAST can be obtained by calling 1-866-GO-EFAST (1-866-463-3278).

A copy of the enclosed Schedule A Insurance Information worksheet will also be available online through the Employer Web link at [www.principal.com](http://www.principal.com). For assistance with enrolling in the Employer Web Service, call the Principal's Advisor Web Support Team at 1-800-554-3395.

If you have questions about the enclosed information, please contact me at the number or email address at the top of this letter.

Enclosure

**Contract #** 1139464  
**Name of Plan** OKELLEY & SOROHAN ATTORN  
**Data Period** April 1, 2022 to March 31, 2023



**Principal Life Insurance Company  
Schedule A (Form 5500) Worksheet**

**Section 1: Coverage**

<b>(A) Name of Insurance Carrier</b> Principal Life Insurance Company		<b>(B) EIN</b> 42-0127290	<b>(C) NAIC Code</b> 61271	
<b>(D) Contract or Id Number</b>	1139464	<b>Approx. no. of Persons cov. At End of Policy Year</b>	<b>Total (E)</b>	<b>282</b>
<b>Combined Numbers</b>			Employees	186
			Dependents	96
Policy or Contract Year From <b>(F)</b> April 1, 2022 To <b>(G)</b> March 31, 2023				

**Section 2: Insurance fee and commissions information**

	<b>(A) Commissions Paid</b>	<b>(B) Fees Paid</b>
Total (from below)	11,596	369

**Section 3: Persons receiving commissions and fees**

<b>(A) Name &amp; Address of Agents or Brokers to whom Commissions or Fees Paid</b>	<b>(B) Amount of Commissions Paid</b>	<b>Fees Paid (C) Amount / (D) Purpose</b>	<b>(E) Org Code</b>
CHASTAIN & ASSOC INS AGCY PO BOX 1908 ATHENS GA 30603-1908	2,481		3 - Ins Agent or Broker
THE CASON GROUP INC 1612 MARION ST COLUMBIA SC 29201-2939	789 8,326 *	369 * Bonus	3 - Ins Agent or Broker

Reportable commissions and fees include all forms of compensation directly or indirectly attributable to your Principal Life Insurance Company policies.

\* This part of the compensation amount reflects a portion of administrative expenses that are allocated across all policies sold by PLIC. It is not part of your actual cost.

**Section 8: Benefit and Contract Type**

<b>(A)</b> Health <small>(other than dental or vision)</small>	<b>(B)</b> <input checked="" type="checkbox"/> Dental	<b>(C)</b> <input checked="" type="checkbox"/> Vision	<b>(D)</b> <input checked="" type="checkbox"/> Life Ins.
<b>(E)</b> Temporary Disability <small>(accident and sickness)</small>	<b>(F)</b> <input checked="" type="checkbox"/> Long Term Disability	<b>(G)</b> Supplemental Unemployment	<b>(H)</b> Prescription Drug
<b>(I)</b> Stop Loss <small>(large deductible)</small>	<b>(J)</b> HMO Contract	<b>(K)</b> <input checked="" type="checkbox"/> PPO Contract	<b>(L)</b> <input checked="" type="checkbox"/> Indemnity Contract
<b>(M)</b> <input checked="" type="checkbox"/> Other: Critical Illness, Accident			

If applicable, the Schedule A worksheet includes voluntary products. If applicable, Basic Life and VTL coverages included AD&D.

**Section 10: Non-Experience Rated Contracts**

<b>(A) Total Premiums Paid to Carrier</b>	177,728
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