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

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

A This return/report is for:
- [ ] a multiemployer plan
- [X] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- [ ] a single-employer plan
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report
- [X] 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:
- [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
TD CONSORTIUM BENEFITS TRUST

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 10/01/2017

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)
TENNESSEE DENTAL ASSOCIATION

600 BAKERS BRIDGE AVENUE
SUITE 300
FRANKLIN, TN 37067

2b Employer Identification Number (EIN) 62-0419454

2c Plan Sponsor's telephone number 800-347-1109

2d Business code (see instructions) 524140

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2024	JEFFREY SMITH
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2024	JEFFREY SMITH
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☐ Same as Plan Sponsor

TD CONSORTIUM BENEFITS TRUST BOARD OF TRUSTEES

6505 LEE HIGHWAY
CHATTANOOGA, TN 37421-2420

3b Administrator's EIN
81-6950155

3c Administrator's telephone number
800-347-1109

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**	0
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)**	
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	0
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	0
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	0
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
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

9a Plan funding arrangement (check all that apply)

- **(1)** ☐ Insurance
- **(2)** ☐ Code section 412(e)(3) insurance contracts
- **(3)** ☒ Trust
- **(4)** ☒ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** ☐ 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
- **(4)** ☐ **DCG** (Individual Plan Information) – Number Attached _____
- **(5)** ☐ **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- **(1)** ☐ **H** (Financial Information)
- **(2)** ☒ **I** (Financial Information – Small Plan)
- **(3)** ☐ **A** (Insurance Information) – Number Attached _____
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☐ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... [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 2023 Form M-1 annual report. If the plan was not required to file the 2023 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 151087037

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.**	**2023** **This Form is Open to Public Inspection.**

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

A Name of plan	**B** Three-digit plan number (PN) ▶
TD CONSORTIUM BENEFITS TRUST	501

C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
TENNESSEE DENTAL ASSOCIATION	62-0419454

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

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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)

AETNA

PO BOX 88863
CHICAGO, IL 60695

06-6033492

(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?
23	NONE	20142	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CONCORD MANAGEMENT RESOURCES

100 MILL RIDGE LANE, SUITE 100
CHESTER, NJ 07930

82-2339246

(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?
16	NONE	34157	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

WINDSOR STRATEGY PARTNERS INC

81-0912547

(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?
11	NONE	7500	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

WITHUMSMITH+BROWN PC

22-2027092

(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	23909	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

(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?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

(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?
			Yes [ ] No [ ]	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

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(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 I (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information—Small Plan

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

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

A Name of plan
TD CONSORTIUM BENEFITS TRUST

B Three-digit plan number (PN) ▶ 501

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

D Employer Identification Number (EIN)
62-0419454

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. 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.**

			(a) Beginning of Year	**(b)** End of Year
1	**Plan Assets and Liabilities:**			
a	Total plan assets	**1a**	699218	0
b	Total plan liabilities	**1b**	301409	0
c	Net plan assets (subtract line 1b from line 1a)	**1c**	397809	0
2	**Income, Expenses, and Transfers for this Plan Year:**		**(a)** Amount	**(b)** Total
a	Contributions received or receivable:			
	(1) Employers	**2a(1)**		
	(2) Participants	**2a(2)**		
	(3) Others (including rollovers)	**2a(3)**		
b	Noncash contributions	**2b**		
c	Other income	**2c**	19998	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	**2d**		19998
e	Benefits paid (including direct rollovers)	**2e**		
f	Corrective distributions (see instructions)	**2f**		
g	Certain deemed distributions of participant loans (see instructions)	**2g**		
h	Administrative service providers (salaries, fees, and commissions)	**2h**		
i	Other expenses	**2i**	417807	
j	Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	**2j**		417807
k	Net income (loss) (subtract line 2j from line 2d)	**2k**		-397809
l	Transfers to (from) the plan (see instructions)	**2l**		

3 **Specific Assets:** If the plan held assets at any time during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

			Yes	No	Amount
a	Partnership/joint venture interests	**3a**		X	
b	Employer real property	**3b**		X	
c	Real estate (other than employer real property)	**3c**		X	
d	Employer securities	**3d**		X	
e	Participant loans	**3e**		X	
f	Loans (other than to participants)	**3f**		X	
g	Tangible personal property	**3g**		X	

Part II Compliance Questions

4 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		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
e Was the plan covered by a fidelity bond?	4e	X		1000000
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		X	
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		X	
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		X	
i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j	X		
k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k		X	
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		X	
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 _____.

Multiple Employer Plan Participating Employer Information
Plan Administrator: TD Consortium Benefits Trust
Plan Sponsor: Tennessee Dental Association
6505 Lee Highway
Chattanooga, TN 37421
EIN: 81-6950155
Plan Number: 501
Business Code: 524140
Signature of Plan Administrator: Jeffrey Smith
Signature of Plan Sponsor: Jeffrey Smith
Plan Administrators Telephone Number: 800-347-1109

Cust ID	(a) Name of Participating Employer	(b) EIN	(c) Percent of Total Contributions	Receipts
T1D00169	12 SOUTH DENTAL	46-1289540	0.00%	0.00
T1D00152	5 STAR DENTAL	80-0144134	0.00%	0.00
T1D00149	615 DENTAL PLLC	47-5094595	0.00%	0.00
T1D00118	ADAMS DENTAL	82-1001596	0.00%	0.00
T1D00084	ALAN W JONES DMD	41-4153891	0.00%	0.00
T1D00159	ALANI DENTAL CENTER	41-3178870	0.00%	0.00
T1D00068	ANDERSON & DITCHARO	47-4374691	0.00%	0.00
T1D00001	APPALACHIAN FAMILY	82-1996644	0.00%	0.00
T1C00010	BACK AND NECK SPECIALISTS, LLC	47-3104963	0.00%	0.00
T1D00121	BENJAMIN DAVID SCOTT	26-3222068	0.00%	0.00
T1C00005	BERRY HILL CHIROPRACTIC & WELLNESS LLC	84-4367437	0.00%	0.00
T1D00162	BLUE HILL FAMILY & COSMETIC DENTISTRY PC	86-3092765	0.00%	0.00
T1D00122	BROGDON DENTAL PC	80-0016166	0.00%	0.00
T1D00097	C DALE SULLIVAN JR	82-3662240	0.00%	0.00
T1D00176	CANE PLLC DBA SALEM CREEK FAMILY DENTISTRY	81-2154056	0.00%	0.00
T1D00156	CANNON ORAL AND MAXILLOFACIAL SURGERY	85-3364361	0.00%	0.00
T1D00133	CAVITY COMMANDOS DEN	83-4626722	0.00%	0.00
T1D00135	CHAD E JOHNSON DDS	20-0685607	0.00%	0.00
T1D00023	CHARLES R QUINN II	62-1412760	0.00%	0.00
T1D00165	COLLEGEDALE FAMILY DENTISTRY	86-2812916	0.00%	0.00
T1C00008	COOPER CHIROPRACTIC	62-1476517	0.00%	0.00
T1D00130	COX ORTHODONTICS PC	83-0664293	0.00%	0.00
T1C00002	CROSS CHIROPRATIC	20-4039074	0.00%	0.00
T1D00007	D.M. GRIMES	62-1292880	0.00%	0.00
T1D00083	DANNY WEISS DDS	62-0865614	0.00%	0.00
T1D00035	DAVID M OWSLEY DMD	46-5186032	0.00%	0.00
T1C00001	DAVID S. PENCE D.C.	62-1219161	0.00%	0.00
T1D00064	DAVID W DICKEY	62-1204685	0.00%	0.00
T1D00039	DAVID W LAMBERT DDS	62-1443489	0.00%	0.00
T1D00124	DAVID W MELTON DDS	62-1193266	0.00%	0.00
T1D00164	DENNIS K ROMAN	62-1434668	0.00%	0.00
T1D00144	DOGWOOD FAMILY DENTAL	84-2535585	0.00%	0.00
T1D00025	DR A LYNN EDELSTEIN	82-3153570	0.00%	0.00
T1D00171	DR. AUSTIN ROBERST FAMILY AND IMPLANT DENTISTRY	47-4733862	0.00%	0.00
T1D00089	EAST BRAINERD ORAL S	27-2031383	0.00%	0.00
T1D00147	EBERTING ORTHODONTICS	62-1076959	0.00%	0.00
T1D00030	ELIZABETH MITCHELL D	47-4523721	0.00%	0.00
T1D00158	FIELDS FAMILY DENTISTRY PLLC	83-4157288	0.00%	0.00
T1D00069	FISCHER FAMILY DENTI	62-1633745	0.00%	0.00
T1D00160	FOREST HILL DENTAL	85-0585816	0.00%	0.00
T1D00104	FOWLER ORTHODONTICS	26-0191169	0.00%	0.00
T1D00161	GARY L WHITE DDS	62-1169409	0.00%	0.00
T1D00150	GENUINE ORTHODONTICS PLLC	84-2769874	0.00%	0.00
T1C00004	GRACEFUL HANDS CHIROPRACTIC & WELLNESS CENTER	47-1355555	0.00%	0.00
T1D00028	GRANT DILLINGHAM	82-2509214	0.00%	0.00
T1D00173	HAPPY TEETH PEDICATRIC DENTISTRY	REQUESTED	0.00%	0.00
T1D00127	HAROLD K WEST III DD	82-3068150	0.00%	0.00
T1D00166	HERMITAGE COSMETIC AND IMPLANT DENTISTRY	86-1355706	0.00%	0.00
T1D00043	HILLSBORO ORTHODONTI	20-2571338	0.00%	0.00
T1D00157	HUTTON FAMILY DENTISTRY	83-3653828	0.00%	0.00
T1D00095	JAMES E CLARK III	41-0355380	0.00%	0.00
T1D00054	JAMES M WILSON DDS	62-1116347	0.00%	0.00
T1D00009	JEFFERY T HIGGS DDS	41-2351251	0.00%	0.00
T1D00168	JER, LLC DBA MAIN STREET DENTAL	20-5203708	0.00%	0.00
T1D00174	JESSE ELLSWORTH D.M.D PLLC DBA CORE DENTAL HEALTH	88-2914547	0.00%	0.00
T1D00139	JESSICA S WANG DDS	Requested	0.00%	0.00

T1D00088	JOHN E TANNER DDS	41-4153891	0.00%	0.00
T1D00080	JOHN F KOTSIANAS	62-1144065	0.00%	0.00
T1D00154	JOHN P HOOVER JR DDS PC	62-1739141	0.00%	0.00
T1C00009	JOHNS CHIROPRACTIC CENTER	62-1395245	0.00%	0.00
T1D00046	JOHNSON CITY SMILES	47-1537877	0.00%	0.00
T1D00114	JOSEPH D HICKS	27-0039249	0.00%	0.00
T1D00137	JOSEPH PAYNE, DDS	Requested	0.00%	0.00
T1D00070	JULIA PRINCE	40-8473186	0.00%	0.00
T1D00075	KNOXVILLE PERIODONTI	62-1062793	0.00%	0.00
T1D00131	KPM DENTAL PARTNERS	83-4267810	0.00%	0.00
T1D00079	L TEMP SULLIVAN PLLC	62-1863737	0.00%	0.00
T1D00108	LAUREN EVERETT SAVEL	27-3135374	0.00%	0.00
T1D00126	LOUIS BONVISSUTO DDS	62-1151290	0.00%	0.00
T1D00100	MARTIN A NUNN DMD	62-1825473	0.00%	0.00
T1D00060	MATTHEW BROCK	45-5041946	0.00%	0.00
T1D00105	MATTHEW NICHOLS ORAL	45-5041946	0.00%	0.00
T1C00007	MICHAEL MASSEY DBA MASSEY CHIROPRACTIC	62-1466420	0.00%	0.00
T1D00140	MISTY HORN BLAKE	Requested	0.00%	0.00
T1D00107	NASHVILLE SMILE TEAM	82-3708779	0.00%	0.00
T1D00094	NATURAL SMILES	62-1617409	0.00%	0.00
T1D00117	NH DENTAL PARTNERS	20-8018145	0.00%	0.00
T1D00145	OAK HILL FAMILY DENTISTRY	47-5505798	0.00%	0.00
T1D00010	ONSTOTT FARRIS FISHE	62-1578738	0.00%	0.00
T1D00172	POLK ORTHODONTICS LLC	88-2821494	0.00%	0.00
T1D00153	PULITZER ORTHODONTICS LLC	20-2983330	0.00%	0.00
T1D00112	RICHARD C RIBEIRO DD	26-0579820	0.00%	0.00
T1D00034	ROSSVIEW DENTAL PLLC	81-3932737	0.00%	0.00
T1D00063	RUSSELL DENTAL GROUP	62-1763558	0.00%	0.00
T1D00142	SCOTT A WALTERS, DDS PC	81-5172235	0.00%	0.00
T1D00099	SEXTON ORAL SURGERY	20-0524891	0.00%	0.00
T1D00014	SHERRYE COSBY DDS	42-1683062	0.00%	0.00
T1D00090	SMILE ON NASHVILLE	82-2589416	0.00%	0.00
T1D00109	SOUTHERN SMILES DENT	81-1449883	0.00%	0.00
T1D00151	STARLING ORTHODONTICS PLLC	75-3167830	0.00%	0.00
T1D00134	SULLIVAN DENTAL PRACTICE	81-4199858	0.00%	0.00
T1D00167	TENNESSEE CENTERS FOR LASER DENTISTRY	20-2159206	0.00%	0.00
T1D00037	TENNESSEE RIVER DENT	47-2248929	0.00%	0.00
T1D00163	TERRY D SAWYER DDS	62-0976539	0.00%	0.00
T1D00006	THE EBLEN AGENCY LLC	46-2118879	0.00%	0.00
T1D00175	THE PRACTICE	84-4716994	0.00%	0.00
T1D00092	TIMOTHY BROWN DDS	20-1615366	0.00%	0.00
T1D00138	TIMOTHY H RAY DDS	62-1289859	0.00%	0.00
T1D00170	VINALL AND SMITH PEDIATRIC DENTISTRY	86-3767210	0.00%	0.00
T1D00129	WESLEY J CHLADNY	82-2948858	0.00%	0.00
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Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

A This return/report is for:
- [ ] a multiemployer plan
- [X] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- [ ] a single-employer plan
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report
- [X] 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:
- [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
TD CONSORTIUM BENEFITS TRUST

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 10/01/2017

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)

TENNESSEE DENTAL ASSOCIATION

600 BAKERS BRIDGE AVENUE
SUITE 300
FRANKLIN, TN 37067

2b Employer Identification Number (EIN) 62-0419454

2c Plan Sponsor's telephone number 800-347-1109

2d Business code (see instructions) 524140

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	Jeffrey R. Smith	10.15.2024	JEFFREY SMITH
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Jeffrey R Smith	10.15.2024	JEFFREY SMITH
	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 (2023)
v. 230728

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V23-6.6F