

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2023

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 08/01/2023 and ending 07/31/2024

- A This return/report is for: a multiemployer plan, a multiple-employer plan, a single-employer plan, a DFE (specify), the first return/report, the final return/report, an amended return/report, a short plan year return/report (less than 12 months)
B This return/report is:
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: DOMINO MANAGEMENT SERVICES LLC LIFE & DISABILITY PLAN
1b Three-digit plan number (PN): 501
1c Effective date of plan: 01/01/2017
2a Plan sponsor's name (employer, if for a single-employer plan): DOMINO MANAGEMENT SERVICES LLC
2b Employer Identification Number (EIN): 16-1642585
2c Plan Sponsor's telephone number: 417-678-8150
2d Business code (see instructions): 561110

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.

Table with 4 columns: Signature label (SIGN HERE), Signature description, Date, and Name. Rows include: Filed with authorized/valid electronic signature (01/09/2025, DENNIS BRIXEY), Signature of plan administrator, Signature of employer/plan sponsor, and Signature of DFE.

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2023) v. 230707

<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>	187
<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>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(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(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</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>	187
	<b>6a(2)</b>	184
	<b>6b</b>	
	<b>6c</b>	
	<b>6d</b>	184
	<b>6e</b>	
	<b>6f</b>	184
	<b>6g(1)</b>	
<b>6g(2)</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>	

**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  
4A 4B 4D 4E 4H 4Q

<b>9a</b> Plan funding arrangement (check all that apply)	<b>9b</b> Plan benefit arrangement (check all that apply)
(1) <input checked="" type="checkbox"/> Insurance	(1) <input checked="" type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input type="checkbox"/> Trust	(3) <input type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> 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)

<b>a Pension Schedules</b>	<b>b General Schedules</b>
(1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information)	(1) <input type="checkbox"/> <b>H</b> (Financial Information)
(2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan)
(3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(3) <input checked="" type="checkbox"/> <b>A</b> (Insurance Information) – Number Attached <u>4</u>
(4) <input type="checkbox"/> <b>DCG</b> (Individual Plan Information) – Number Attached _____	(4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information)
(5) <input type="checkbox"/> <b>MEP</b> (Multiple-Employer Retirement Plan 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 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 \_\_\_\_\_

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**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Insurance Information**

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

**2023**

**This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning **01/01/2023** and ending **07/31/2023**

<b>A</b> Name of plan <b>DOMINO MANAGEMENT SERVICES LLC LIFE &amp; DISABILITY PLAN</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>DOMINO MANAGEMENT SERVICES LLC</b>	<b>D</b> Employer Identification Number (EIN) <b>16-1642585</b>

**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  
**SUN LIFE ASSURANCE COMPANY OF CANADA**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>81-1082080</b>	<b>80802</b>	<b>202637</b>	<b>146</b>	<b>08/01/2023</b>	<b>07/31/2024</b>

**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>3674</b>	<b>(b)</b> Total amount of fees paid
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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  
**MARSH & MCLENNAN AGENCY LLC** **PO BOX 350**  
**CONSHOHOCKEN, PA 19428**

<b>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	
<b>3674</b>			<b>3</b>

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

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

<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.
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<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:

<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"/>		

**7** 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>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
	<b>7c(6)</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>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
	<b>7e(5)</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) ▶ **AD&D, CHILD OPTIONS LIFE, EMPLOYEE OPTIONAL LIFE, SPOUSE OPTIONAL LIFE**

**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>	0
<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>	67558
<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 .....	<b>10b</b>	

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. ▶

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>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><b>2023</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2023 or fiscal plan year beginning **01/01/2023** and ending **07/31/2023**

<p><b>A</b> Name of plan <b>DOMINO MANAGEMENT SERVICES LLC LIFE &amp; DISABILITY 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>DOMINO MANAGEMENT SERVICES LLC</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>16-1642585</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  
**AMERITAS LIFE INSURANCE CORP. OF NEW YORK**

(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
47-0098400	61301	010-036987	184	08/01/2023	07/31/2024

**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.

<p>(a) Total amount of commissions paid <b>4787</b></p>	<p>(b) Total amount of fees paid <b>968</b></p>
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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

**MARSH & MCLENNAN AGENCY LLC**      **LIBERTY TOWER SUITE 500**  
**605 CHESTNUT ST**  
**CHATTANOOGA, TN 37450**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4787			3

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

**MARSH & MCLENNAN AGENCY LLC**      **11330 LAKEFIELD DR**  
**STE 100 BLDG 1**  
**DULUTHY, GA 30097**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	968	<b>SUPPLEMENTAL FEES</b>	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.
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<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:

<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"/>		

**7** 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>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<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>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<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>	47872
<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 .....	<b>10b</b>	

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. ▶



(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>	

**6** 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"/>		

**7** 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>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
	<b>7c(6)</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>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
	<b>7e(5)</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)
- |  |  |   |  |
|--|--|---|--|
| <b>a</b> <input type="checkbox"/> Health (other than dental or vision)         | <b>b</b> <input checked="" type="checkbox"/> Dental    | <b>c</b> <input checked="" type="checkbox"/> Vision         | <b>d</b> <input type="checkbox"/> Life insurance     |
| <b>e</b> <input type="checkbox"/> Temporary disability (accident and sickness) | <b>f</b> <input type="checkbox"/> Long-term disability | <b>g</b> <input type="checkbox"/> Supplemental unemployment | <b>h</b> <input type="checkbox"/> Prescription drug  |
| <b>i</b> <input type="checkbox"/> Stop loss (large deductible)                 | <b>j</b> <input type="checkbox"/> HMO contract         | <b>k</b> <input type="checkbox"/> PPO contract              | <b>l</b> <input type="checkbox"/> Indemnity contract |
| <b>m</b> <input type="checkbox"/> 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>
<b>10</b> Nonexperience-rated contracts:		
<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	54532
<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 .....	<b>10b</b>	

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. ▶



(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>		34841
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		36707
	(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>	71548
	(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>		258714
<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 .....	<b>10b</b>		

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. ▶

<b>SCHEDULE C</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Service Provider Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2023</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2023 or fiscal plan year beginning **08/01/2023** and ending **07/31/2024**

<b>A</b> Name of plan <b>DOMINO MANAGEMENT SERVICES LLC LIFE &amp; DISABILITY PLAN</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>DOMINO MANAGEMENT SERVICES LLC</b>	<b>D</b> Employer Identification Number (EIN) <b>16-1642585</b>	

**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

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**(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

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**(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

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**(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)

CIGNA HEALTH AND LIFE INSURANCE COM

6625 W 78TH ST 260  
#280  
MINNEAPOLIS, MN 55439

59-1031071

(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 31 38 49 50 56 62	SERVICE PROVIDER	2226	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**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.

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

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

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

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

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

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

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> 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)

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB 1545-0047 1210-0009

2023

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

This form is required to be filed for each employee benefit plan under sections 101 and 105 of the Internal Revenue Code and section 199 of the Internal Revenue Code.

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

Part I Annual Report Identification Information

For the plan year 2023 or its beginning year beginning 08/01/2023 and ending 07/31/2024

- A This return/report is for: a) a defined employer plan, b) a defined employer plan (FERS election) or a defined employer plan in a defined contribution plan, c) a simplified employer plan, d) a defined employer plan (DFP) or a defined employer plan (DFP) extension, e) a defined employer plan (DFP) extension (enter description), f) a defined employer plan (DFP) extension (enter description), g) a defined employer plan (DFP) extension (enter description), h) a defined employer plan (DFP) extension (enter description), i) a defined employer plan (DFP) extension (enter description), j) a defined employer plan (DFP) extension (enter description), k) a defined employer plan (DFP) extension (enter description), l) a defined employer plan (DFP) extension (enter description), m) a defined employer plan (DFP) extension (enter description), n) a defined employer plan (DFP) extension (enter description), o) a defined employer plan (DFP) extension (enter description), p) a defined employer plan (DFP) extension (enter description), q) a defined employer plan (DFP) extension (enter description), r) a defined employer plan (DFP) extension (enter description), s) a defined employer plan (DFP) extension (enter description), t) a defined employer plan (DFP) extension (enter description), u) a defined employer plan (DFP) extension (enter description), v) a defined employer plan (DFP) extension (enter description), w) a defined employer plan (DFP) extension (enter description), x) a defined employer plan (DFP) extension (enter description), y) a defined employer plan (DFP) extension (enter description), z) a defined employer plan (DFP) extension (enter description).

Part II Basic Plan Information—enter or check as applicable in the plan

1a Name of plan: DOMINO MANAGEMENT SERVICES LLC LIFE & DISABILITY PLAN
1b Plan number: 501
1c Effective date: 01/01/2017
2a Plan sponsor's name: DOMINO MANAGEMENT SERVICES LLC
2b Employer identification number: 16-1642585
2c Plan sponsor's telephone number: 417-678-8150
2d Business code: 561110

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

Under penalties perjury and other penalties set forth in the instructions, I declare under penalty of perjury that the information provided on this return/report is true and correct and that I am the duly authorized officer and controller of the plan and that the information provided is true and correct.

Table with 4 columns: SIGN HERE, Signature, Date, and Name/Title. Row 1: Dennis Brixey, 1/09/25, CFO. Row 2: Signature of employer/plan sponsor, Date, Name/Title. Row 3: Signature of DFE, Date, Name/Title.

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Sole Dis Plan Sponsor	<b>3b</b> Administrator's EIN
	<b>3c</b> Administrator's telephone number

<b>4</b> Enter the name and/or EIN of the plan sponsor or the plan name as indicated since the disbursement/reported for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the disbursement/reported	<b>4b</b> CI
	<b>4d</b> CC

<b>5</b> Pension or annuity contract's effective beginning plan year	<b>5</b>	187
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<b>6</b> Enter contract's effective end plan year unless otherwise stated elsewhere on this form only lines 6a(1), 6a(2), 6b, 6c, and 6d		
	<b>6a(1)</b> Pension or annuity contract's effective beginning plan year	187
	<b>6a(2)</b> Pension or annuity contract's effective end plan year	184
	<b>b</b> Retired or separated contract's recipient benefits	<b>6b</b>
	<b>c</b> Other retired or separated contract's entitled to other benefits	<b>6c</b>
	<b>d</b> See attached lines 6a(2), 6b, and 6c	<b>6d</b> 184
	<b>e</b> Deceased contract's estate beneficiaries are recipient or are entitled to receive benefits	<b>6e</b>
	<b>f</b> See attached lines 6d and 6e	<b>6f</b> 184
<b>g(1)</b> Enter contract's first termination date as effective beginning plan year only defined contribution plans	<b>6g(1)</b>	
<b>g(2)</b> Enter contract's first termination date as effective end plan year only defined contribution plans	<b>6g(2)</b>	
<b>h</b> Enter contract's first termination date as effective end plan year of reported benefits were less than 100 cases	<b>6h</b>	

<b>7</b> Enter the pension or annuity contract's first termination date as effective beginning plan year only defined contribution plans	<b>7</b>
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**8a** Enter the pension or annuity contract's first termination date as effective beginning plan year only defined contribution plans

**b** Enter the pension or annuity contract's first termination date as effective beginning plan year only defined contribution plans

4A 4B 4D 4E 4H 4Q

<b>9a</b> Plan termination arrangement type	<b>9b</b> Plan termination arrangement type
(1) <input checked="" type="checkbox"/> Insurance	(1) <input checked="" type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 12(e) insurance contracts	(2) <input type="checkbox"/> Code section 12(e) insurance contracts
(3) <input type="checkbox"/> Trust	(3) <input type="checkbox"/> Trust
(4) <input type="checkbox"/> Other assets of the sponsor	(4) <input type="checkbox"/> Other assets of the sponsor

**10** Check appropriate boxes in 10 and 10 to indicate if schedules are reported, and, where indicated, enter the number reported (See instructions)

**a Pension Schedules**

(1)  R (Retiree) enrollment in the plan

(2)  MB (Monthly) Employer Defined Benefit and Certain Money purchase plan contributions or annuities provided by the plan

(3)  SB (Single) Employer Defined Benefit contributions in the plan provided by the plan

(4)  DCG (Individual) Enrollment in the plan - other than reported

(5)  MEP (Monthly) Employer Retirement enrollment in the plan

**b General Schedules**

(1)  H (Financial) enrollment

(2)  I (Financial) enrollment - See instructions

(3)  A (Insurance) Enrollment - other than reported 4

(4)  C (Service Provider) Enrollment

(5)  D (DF/Contributions) Enrollment

(6)  G (Financial) Contributions Schedules

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

**11a** Does the plan provide the benefits, or is the plan subject to the Form M-1 filing requirements during the year? (See instructions and 29 CFR 2520.101-2.) .....  Yes  No

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

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

**11c** Enter the Receipt/Contribution Code for the 2020 Form M-1 announcement. If the plan is not required to file the 2020 Form M-1 announcement, enter the Receipt/Contribution Code for the disclosure Form M-1 documents required to be filed under the Form M-1 filing requirements. If there is no code, enter 0000. Receipt/Contribution Code is a 4-digit Form 5500 filing identification code.

Receipt/Contribution Code: .....

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefits Security Administration

**Insurance Information**

This schedule is required to be filed under section 101 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance contracts are required to provide the information described in ERISA section 101.2

OMB 1545-0047

**2023**

**This Form is Open to Public Inspection**

For the calendar year 2023 or fiscal year beginning 08/01/2023

and ending 07/31/2024

**A** Name of the plan  
DOMINO MANAGEMENT SERVICES LLC LIFE & DISABILITY PLAN

**B** Record of the plan number  
501

**C** Plan sponsor's name as shown on line 2 of Form 5500  
DOMINO MANAGEMENT SERVICES LLC

**D** Employer Identification Number  
16-1642585

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract in separate Schedule of Individual Contracts or pooled contracts in Part II and III which are required on this Schedule.

**1** Contract information

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

(b) ID	(c) IC Code	(d) Contract identification number	(e) Approximate number of persons covered by the policy or contract	Policy or contract year	
				(f) From	(g) To
59-1031071	67369	00650840	58	08/01/2023	07/31/2024

**2** Insurance fee and commission information. Provide the amounts and percentages of commissions paid to the agent, brokers, and other persons in descending order of the amount paid.

(a) Commission percentages paid	(b) Commission amounts paid
34841	11935

**3** Persons receiving commissions and fees. Complete as many entries as needed to report 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 4TH FLOOR COLUMBIA, SC 29201

(b) Commission fees and other commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Description	
	11935	GENERAL AGENT FEES	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
MARSH & MCLENNAN AGENCY LLC LIBERTY TOWER SUITE 500 605 CHESTNUT ST CHATTANOOGA, TN 37450

(b) Commission fees and other commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Description	
34841			3

(a) Fee and address of the person, or other person, who issues or fees are paid

(b) Person's name and fee issue ID	Fees and other issue ID		(e) Organization code
	(c) Person	(d) Fee	

(a) Fee and address of the person, or other person, who issues or fees are paid

(b) Person's name and fee issue ID	Fees and other issue ID		(e) Organization code
	(c) Person	(d) Fee	

(a) Fee and address of the person, or other person, who issues or fees are paid

(b) Person's name and fee issue ID	Fees and other issue ID		(e) Organization code
	(c) Person	(d) Fee	

(a) Fee and address of the person, or other person, who issues or fees are paid

(b) Person's name and fee issue ID	Fees and other issue ID		(e) Organization code
	(c) Person	(d) Fee	

(a) Fee and address of the person, or other person, who issues or fees are paid

(b) Person's name and fee issue ID	Fees and other issue ID		(e) Organization code
	(c) Person	(d) Fee	

**Part II Investment and Annuity Contract Information**  
 If there are individual annuities or contracts, the entire Form 5500-2020 individual annuities or contracts should be reported as an individual annuity or contract.

<b>4</b> Current value of plan's interest under this contract in the general account at year end	<input type="text"/>	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate <input type="text"/> account's <input type="text"/> year end	<input type="text"/>	<b>5</b>	

**6** Contracts in  individual Funds

**a** State the basis accounting rates

**b** Prepaid cost of carrier

**c** Prepaid cost of annuity at the end of the year

**d** If the carrier, service, or other provision inurred any special costs in connection with the acquisition or retention of the contract, enter on this line the amount of such costs

**e** Type of contract  individual annuities  or deferred annuity  other security

**f** If non-annuity, in whole or in part, distribute benefits from or terminate, see Form

<b>6b</b>	<input type="text"/>
<b>6c</b>	<input type="text"/>
<b>6d</b>	<input type="text"/>

**7** Contracts in  individual Funds Do not include portions of these contracts contained in separate accounts

**a** Type of contract  deposited in  in  immediate annuity  or  other

**b** Balance at the end of the year

**c** Additions of  Contributions deposited during the year

<input type="checkbox"/> Dividends and credits <input type="text"/>	<b>7c(1)</b>	<input type="text"/>
<input type="checkbox"/> Interest credited during the year <input type="text"/>	<b>7c(2)</b>	<input type="text"/>
<input type="checkbox"/> Transferred from separate account <input type="text"/>	<b>7c(3)</b>	<input type="text"/>
<input type="checkbox"/> Other security <input type="text"/>	<b>7c(4)</b>	<input type="text"/>
<input type="checkbox"/>	<b>7c(5)</b>	<input type="text"/>
<input type="checkbox"/>	<b>7c(6)</b>	<input type="text"/>

**d** Deductions

<input type="checkbox"/> Disbursed from and to pay benefits or purchase annuities during year <input type="text"/>	<b>7e(1)</b>	<input type="text"/>
<input type="checkbox"/> Paid in <input type="checkbox"/> or <input type="checkbox"/> by carrier <input type="text"/>	<b>7e(2)</b>	<input type="text"/>
<input type="checkbox"/> Transferred to separate account <input type="text"/>	<b>7e(3)</b>	<input type="text"/>
<input type="checkbox"/> Other security <input type="text"/>	<b>7e(4)</b>	<input type="text"/>
<input type="checkbox"/>	<b>7e(5)</b>	<input type="text"/>

**f** Balance at the end of the year  is  line **7e(5)**  line **7d**

<b>7f</b>	<input type="text"/>
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**Part III Welfare Benefit Contract Information**  
 If you are one of the contributors to the plan or the employees of the employer or the employee organizations, the information you are required to provide on this form is based on the experience of the plan or the employee organizations. If you are an individual contributor, the information is based on the experience of the plan or the employee organizations.

- 8** Benefit and contribution bases
- a**  Death benefit
  - b**  Disability
  - c**  Pension
  - d**  Life insurance
  - e**  Long-term disability and sickness
  - f**  Accidental death
  - g**  Supplemental annuity
  - h**  Prescription drug
  - i**  Short-term disability
  - j**  FICA taxes
  - k**  Other contributions
  - l**  Indemnity benefits
  - m**  Other benefits

**9** Experienced contracts

<b>a</b> Pre-1981 contract received	<b>9a(1)</b>	
Increase decrease in annual contribution	<b>9a(2)</b>	
Increase decrease in the fixed rate reserve	<b>9a(3)</b>	
Contract (1) (2) (3)	<b>9a(4)</b>	
<b>b</b> Benefit bases of costs paid	<b>9b(1)</b>	
Increase decrease in the reserve	<b>9b(2)</b>	
Inferred costs add (1) and (2)	<b>9b(3)</b>	
Costs added	<b>9b(4)</b>	
<b>c</b> Reimbursement of retention costs in the contract		
Commissions	<b>9c(1)(A)</b>	34841
Board initiative service or other fees	<b>9c(1)(B)</b>	36707
Contract administration costs	<b>9c(1)(C)</b>	
Other expenses	<b>9c(1)(D)</b>	
Fees	<b>9c(1)(E)</b>	
FICA taxes or other contingencies	<b>9c(1)(F)</b>	
Other retention costs	<b>9c(1)(G)</b>	
Retention	<b>9c(1)(H)</b>	71548
Dividends or retrospective rate refunds case or not	<b>9c(2)</b>	
<b>d</b> Status liability reserves end year	<b>9d(1)</b>	
Contract reserves	<b>9d(2)</b>	
Other reserves	<b>9d(3)</b>	
<b>e</b> Dividends or retrospective rate refunds due to non-increase	<b>9e</b>	
<b>10</b> Unexperienced contracts		
<b>a</b> Pre-1981 or subscription contracts paid to carrier	<b>10a</b>	258714
<b>b</b> From carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract, other than reported in part, line 2 above, retrospective	<b>10b</b>	

**Part IV Provision of Information**

- 11** Did the insurance company provide any information necessary to complete Schedule F?  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 Benefits Security Administration

**Insurance Information**

This schedule is required to be filed under section 101 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance contracts are required to provide the information described in ERISA section 101.2

OMB 1545-0047

**2023**

**This Form is Open to Public Inspection**

For the calendar year 2023 or fiscal year beginning 01/01/2023

and ending 07/31/2023

**A** Name of the plan  
DOMINO MANAGEMENT SERVICES LLC LIFE & DISABILITY PLAN

**B** Record of the plan number  
501

**C** Plan sponsor's name as shown on line 2 of Form 5500  
DOMINO MANAGEMENT SERVICES LLC

**D** Employer Identification Number  
16-1642585

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract in separate Schedule of Individual Contracts provided to you in the Schedule II and III that are required on this Schedule.

**1** Contract information

(a) Name of the insurance carrier  
AMERITAS LIFE INSURANCE CORP. OF NEW YORK

(b) ID	(c) ICD code	(d) Contract identification number	(e) Approximate number of persons covered end of policy or anniversary	Policy or anniversary	
				(f) From	(g) To
47-0098400	61301	010-036987	184	08/01/2023	07/31/2024

**2** Insurance fee and commission information. Provide the amounts and number of commissions paid to you in the policy, orders, and other persons in descending order of the amount paid.

(a) Number of commissions paid	(b) Number of policies paid
4787	968

**3** Persons receiving commissions and fees. Complete as many entries as needed to report persons.

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

MARSH & MCLENNAN AGENCY LLC  
LIBERTY TOWER SUITE 500  
605 CHESTNUT ST  
CHATTANOOGA, TN 37450

(b) Total commissions and fees paid	Fees and other commissions paid		(e) Organization code
	(c) Total	(d) Expense	
4787			3

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

MARSH & MCLENNAN AGENCY LLC  
11330 LAKEFIELD DR  
STE 100 BLDG 1  
DULUTHY, GA 30097

(b) Total commissions and fees paid	Fees and other commissions paid		(e) Organization code
	(c) Total	(d) Expense	
	968	SUPPLEMENTAL FEES	3

(a) The end address of the plan, or the person in charge of the plan or fees here

(b) The plan's EIN and the plan's ID	Fees and other charges		(e) Organization code
	(c) Plan	(d) Expense	

(a) The end address of the plan, or the person in charge of the plan or fees here

(b) The plan's EIN and the plan's ID	Fees and other charges		(e) Organization code
	(c) Plan	(d) Expense	

(a) The end address of the plan, or the person in charge of the plan or fees here

(b) The plan's EIN and the plan's ID	Fees and other charges		(e) Organization code
	(c) Plan	(d) Expense	

(a) The end address of the plan, or the person in charge of the plan or fees here

(b) The plan's EIN and the plan's ID	Fees and other charges		(e) Organization code
	(c) Plan	(d) Expense	

(a) The end address of the plan, or the person in charge of the plan or fees here

(b) The plan's EIN and the plan's ID	Fees and other charges		(e) Organization code
	(c) Plan	(d) Expense	

**Part II Investment and Annuity Contract Information**  
 If there are individual annuities or contracts, the entire Form 5500-2020 individual annuities or contracts should be reported as an individual annuity or contract.

<b>4</b> Current value of plan's interest under this contract in the general account at year end	<input type="text"/>	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate <input type="text"/> account's <input type="text"/> year end	<input type="text"/>	<b>5</b>	

**6** Contracts in  individual Funds

**a** State the basis accounting rates

**b** Prepaid cost of carrier

**c** Prepaid cost of annuity at the end of the year

**d** If the carrier, service, or other provision inurred any special costs in connection with the acquisition or retention of the contract, enter on this line the amount of such costs

**e** Type of contract  individual annuities  or deferred annuity  other security

**f** If non-annuity, in whole or in part, distribute benefits from or terminate, see Form

<b>6b</b>	<input type="text"/>
<b>6c</b>	<input type="text"/>
<b>6d</b>	<input type="text"/>

**7** Contracts in  individual Funds Do not include portions of these contracts contained in separate accounts

**a** Type of contract  deferred annuity  immediate annuity  other

**b** Balance at the end of the year

**c** Additions of contracts deposited during the year

<input type="checkbox"/> Dividends and credits	<b>7c(1)</b>	<input type="text"/>
<input type="checkbox"/> Interest credited during the year	<b>7c(2)</b>	<input type="text"/>
<input type="checkbox"/> Transferred from separate account	<b>7c(3)</b>	<input type="text"/>
<input type="checkbox"/> Other security fee	<b>7c(4)</b>	<input type="text"/>
<input type="checkbox"/> Other	<b>7c(5)</b>	<input type="text"/>
<input type="checkbox"/> Total additions	<b>7c(6)</b>	<input type="text"/>

**d** Deductions and additions add lines **7b** and **7c(6)**

**e** Deductions

<input type="checkbox"/> Disbursed from and to pay benefits or purchase annuities during year	<b>7e(1)</b>	<input type="text"/>
<input type="checkbox"/> Paid in connection with cost of carrier	<b>7e(2)</b>	<input type="text"/>
<input type="checkbox"/> Transferred to separate account	<b>7e(3)</b>	<input type="text"/>
<input type="checkbox"/> Other security fee	<b>7e(4)</b>	<input type="text"/>
<input type="checkbox"/> Total deductions	<b>7e(5)</b>	<input type="text"/>

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

<b>7f</b>	<input type="text"/>
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**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefits Security Administration

**Insurance Information**

This schedule is required to be filed under section 101 of the Employee Retirement Income Security Act of 1974 (ERISA)

▶ File as an attachment to Form 5500.

▶ Insurance contracts are required to provide the information described in ERISA section 101(b)(2)

OMB 1545-0047

**2023**

**This Form is Open to Public Inspection**

For the calendar year 2023 or fiscal year beginning 01/01/2023

and ending 07/31/2023

**A** Name of the plan  
DOMINO MANAGEMENT SERVICES LLC LIFE & DISABILITY PLAN

**B** Record of the plan number  
501

**C** Plan sponsor's name as shown on line 2 of Form 5500  
DOMINO MANAGEMENT SERVICES LLC

**D** Employer Identification Number  
16-1642585

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract in separate Schedule of Individual Contracts or pooled contracts in Part II and III which are required to include Schedule of

**1** Contract Information

(a) Name of insurance carrier  
SUN LIFE ASSURANCE COMPANY OF CANADA

(b) ID	(c) ICD code	(d) Contract identification number	(e) Approximate number of persons covered end of policy or anniversary	Policy or anniversary	
				(f) From	(g) To
81-1082080	80802	202637	146	08/01/2023	07/31/2024

**2** Insurance fee and commission information. Provide the amounts and percentages of commissions paid to the agent, brokers, and other persons in descending order of the amount paid.

(a) Total commissions paid 3674	(b) Total net premiums paid
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**3** Persons receiving commissions and fees. Complete as many entries as needed to report persons.

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

MARSH & MCLENNAN AGENCY LLC  
PO BOX 350  
CONSHOHOCKEN, PA 19428

(b) Total commissions and fees paid	Fees and other commissions paid		(e) Organization code
	(c) Total	(d) Expense	
3674			3

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

(b) Total commissions and fees paid	Fees and other commissions paid		(e) Organization code
	(c) Total	(d) Expense	

(a) The end address of the plan, or the person in charge of the plan or fees here

(b) The plan's EIN and the plan's ID	Fees and other charges		(e) Organization Code
	(c) Plan	(d) Expense	

(a) The end address of the plan, or the person in charge of the plan or fees here

(b) The plan's EIN and the plan's ID	Fees and other charges		(e) Organization Code
	(c) Plan	(d) Expense	

(a) The end address of the plan, or the person in charge of the plan or fees here

(b) The plan's EIN and the plan's ID	Fees and other charges		(e) Organization Code
	(c) Plan	(d) Expense	

(a) The end address of the plan, or the person in charge of the plan or fees here

(b) The plan's EIN and the plan's ID	Fees and other charges		(e) Organization Code
	(c) Plan	(d) Expense	

(a) The end address of the plan, or the person in charge of the plan or fees here

(b) The plan's EIN and the plan's ID	Fees and other charges		(e) Organization Code
	(c) Plan	(d) Expense	

**Part II Investment and Annuity Contract Information**  
 If there are individual annuities or contracts, the entire Form 5500-2020 individual annuities or contracts should be reported as an individual annuity or contract.

<b>4</b> Current value of plan's interest under this contract in the general account at year end	<input type="text"/>	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate <input type="text"/> account's <input type="text"/> year end	<input type="text"/>	<b>5</b>	

**6** Contracts in  Individual Funds

**a** State the basis accounting rates

**b** Pre-1982 and  carrier

**c** Pre-1982 due  month  day

**d** If the carrier, service, or other provision in  any state  basis in  connection  of  the  provision  or  relation  of  the  contract  or  policy, enter  on  the  contract  or  policy  the  state  or  other  basis

**e** Type  of  individual  annuities  or  deferred  annuity  or  other  policy

**f**  Contract  or  contract, in  state  or  in  any  of  distribute  benefits  from  or  in  the  plan,  the  state

**7** Contracts in  Individual Funds  Do  not  include  portions  of  these  contracts  defined  in  separate  accounts

**a** Type  of  individual  annuities  or  deferred  annuity  or  other  policy

**b** Balance  at  the  end  of  the  year

**c** Additions  of  contributions  deposited  during  the  year

<input type="checkbox"/> Dividends and credits	<b>7c(1)</b>	
<input type="checkbox"/> Interest credited during the year	<b>7c(2)</b>	
<input type="checkbox"/> Transferred from separate account	<b>7c(3)</b>	
<input type="checkbox"/> Other security	<b>7c(4)</b>	
<input type="checkbox"/>	<b>7c(5)</b>	

**d**  Additions  and  additions  add  lines  7b  and  7c(6)

**e** Deductions

<input type="checkbox"/> Disbursed from and to any benefits or purchase annuities during year	<b>7e(1)</b>	
<input type="checkbox"/> Deduction made by carrier	<b>7e(2)</b>	
<input type="checkbox"/> Transferred to separate account	<b>7e(3)</b>	
<input type="checkbox"/> Other security	<b>7e(4)</b>	

**f** Balance  at  the  end  of  the  year  is  reported  on  line  7e(5)  of  line  7d

**Part III Welfare Benefit Contract Information**  
 This information is required for all welfare benefit contracts that provide benefits to employees or former employees of the employer or former employee organizations. If the information is not provided for a contract, the contract is not an eligible contract. If the contract is an eligible contract, the entire contract information is required to be reported on this return.

- 8** Benefit and contribution bases:
- a**  Death benefit or death disbursement
  - b**  Disability
  - c**  Pension
  - d**  Life insurance
  - e**  Long-term disability, indemnity and sickness
  - f**  Accidental death
  - g**  Supplemental unemployment benefits
  - h**  Prescription drug
  - i**  Short-term disability
  - j**  FICA contributions
  - k**  Other contributions
  - l**  Indemnity contributions
  - m**  Other benefits **▶ AD&D, CHILD OPTIONS LIFE, EMPLOYEE OPTIONAL LIFE, SPOUSE OPTIONAL LIFE**

**9** Experienced contracts

<b>a</b> Pre-1981 contracts received	<b>9a(1)</b>	
Increase decrease in annual contribution	<b>9a(2)</b>	
Increase decrease in the fixed pre-1981 reserve	<b>9a(3)</b>	
Contracted (1) (2) (3)	<b>9a(4)</b>	0
<b>b</b> Benefit bases of contracts paid	<b>9b(1)</b>	
Increase decrease in the reserve	<b>9b(2)</b>	
Contracted (1) and (2)	<b>9b(3)</b>	
Contracts paid	<b>9b(4)</b>	
<b>c</b> Reimbursement or retention bases in the contract		
Contract commissions	<b>9c(1)(A)</b>	
Board initiative service or other fees	<b>9c(1)(B)</b>	
Contract specific commission basis	<b>9c(1)(C)</b>	
Other expenses	<b>9c(1)(D)</b>	
Fees	<b>9c(1)(E)</b>	
FICA or other contributions	<b>9c(1)(F)</b>	
Other retention bases	<b>9c(1)(G)</b>	
Retention	<b>9c(1)(H)</b>	
Dividends or retrospective rate refunds case or basis were paid in cash, or credited	<b>9c(2)</b>	
<b>d</b> Spouse beneficiary reserves end year or end of contract or other benefits after retirement	<b>9d(1)</b>	
Contract reserves	<b>9d(2)</b>	
Other reserves	<b>9d(3)</b>	
<b>e</b> Dividends or retrospective rate refunds that do not include or are entered in line 9c(2)	<b>9e</b>	
<b>10</b> Unexperienced contracts		
<b>a</b> Pre-1981 or subscription contracts paid to carrier	<b>10a</b>	67558
<b>b</b> From carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract, other than reported in part, line 2 above, reported on	<b>10b</b>	

**Part IV Provision of Information**

- 11** Did the insurance policy provide any information necessary to complete Schedule F?  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 Benefits Advisory Corporation

**Insurance Information**

This schedule is required to be filed under section 101 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance contracts are required to provide the information described in ERISA section 101.2

OMB 1545-0047

**2023**

**This Form is Open to Public Inspection**

For the calendar year 2023 or fiscal year beginning 01/01/2023

and ending 07/31/2023

**A** Name of the plan  
DOMINO MANAGEMENT SERVICES LLC LIFE & DISABILITY PLAN

**B** Record of the plan number  
501

**C** Plan sponsor's name as shown on line 2 of Form 5500  
DOMINO MANAGEMENT SERVICES LLC

**D** Employer Identification Number  
16-1642585

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on separate Schedule B Individual Contracts or pooled contracts in Parts II and III when the required on single Schedule B

**1** Contract Information

(a) Name of the insurance carrier  
AMERITAS LIFE INSURANCE CORP. OF NEW YORK

(b) ID	(c) ICD code	(d) Contract identification number	(e) Approximate number of persons covered and city or country	City or country	
				(f) From	(g) To
47-0098400	61301	010-050827	136	08/01/2023	07/31/2024

**2** Insurance fee and commission information. Provide fees and commissions paid to the agent, brokers, and other persons in descending order of the amount paid

(a) Commission or fee paid	(b) Commission or fee paid
7089	

**3** Persons receiving commissions and fees. Complete as many entries as needed to report persons

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

HAND, MICHAEL, DENNIS  
100 CORPORATE POINTE  
SUITE 210  
CULVER CITY, CA 90230

(b) Commission or fee paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Code	
5453			3

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

EMERSON REID LLC  
1787 SENTRY PARKWAY  
SUITE 320  
BLUE BELL, PA 19422

(b) Commission or fee paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Code	
1636			3

(a) Fee and address of the person, or other person or persons or fees here

(b) Description and fee issuance	Fees and other issuances		(e) Organization code
	(c) Amount	(d) Description	

(a) Fee and address of the person, or other person or persons or fees here

(b) Description and fee issuance	Fees and other issuances		(e) Organization code
	(c) Amount	(d) Description	

(a) Fee and address of the person, or other person or persons or fees here

(b) Description and fee issuance	Fees and other issuances		(e) Organization code
	(c) Amount	(d) Description	

(a) Fee and address of the person, or other person or persons or fees here

(b) Description and fee issuance	Fees and other issuances		(e) Organization code
	(c) Amount	(d) Description	

(a) Fee and address of the person, or other person or persons or fees here

(b) Description and fee issuance	Fees and other issuances		(e) Organization code
	(c) Amount	(d) Description	

**Part II Investment and Annuity Contract Information**  
 If there are individual annuities or contracts, the entire Form 5500-2020 individual annuities or contracts should be reported as an individual annuity or contract.

<b>4</b> Current value of plan's interest under this contract in the general account at year end	<input type="text"/>	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate <input type="text"/> account's <input type="text"/> year end	<input type="text"/>	<b>5</b>	

**6** Contracts in  Individual Funds

**a** State the basis accounting rates

**b** Prepaid cost of carrier

**c** Prepaid cost of annuity at the end of the year

**d** If the carrier, service, or other provision inurred any special costs in connection with the acquisition or retention of the contract, enter on this line the amount of such costs

**e** Type of contract  individual  2  or deferred annuity  other specify

**f** If non-annuitized, in whole or in part, distribute benefits from or terminate, describe

<b>6b</b>	<input type="text"/>
<b>6c</b>	<input type="text"/>
<b>6d</b>	<input type="text"/>

**7** Contracts in  Individual Funds Do not include portions of these contracts contained in separate accounts

**a** Type of contract  decession initiation  2  immediate annuity  other

**b** Balance at the end of the year

**c** Additions of contracts decession during the year

<input type="checkbox"/> Dividends and credits	<b>7c(1)</b>	<input type="text"/>
<input type="checkbox"/> Interest credited during the year	<b>7c(2)</b>	<input type="text"/>
<input type="checkbox"/> Transferred from separate account	<b>7c(3)</b>	<input type="text"/>
<input type="checkbox"/> Other specify <input type="text"/>	<b>7c(4)</b>	<input type="text"/>
<input type="checkbox"/>	<b>7c(5)</b>	<input type="text"/>
<input type="checkbox"/>	<b>7c(6)</b>	<input type="text"/>

**d** Deductions and additions add lines 7b and 7c(6)

**e** Deductions

<input type="checkbox"/> Disbursed from and to pay benefits or purchase annuities during year	<b>7e(1)</b>	<input type="text"/>
<input type="checkbox"/> Deduction made by carrier	<b>7e(2)</b>	<input type="text"/>
<input type="checkbox"/> Transferred to separate account	<b>7e(3)</b>	<input type="text"/>
<input type="checkbox"/> Other specify <input type="text"/>	<b>7e(4)</b>	<input type="text"/>
<input type="checkbox"/>	<b>7e(5)</b>	<input type="text"/>

**f** Balance at the end of the year is reported on line 7e(5) or line 7d

<b>7f</b>	<input type="text"/>
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**Part III Welfare Benefit Contract Information**  
 If you are one of the contributors to the plan or the employees of the service provider or the service provider's employees or subsidiaries, the information you are required to provide on this form is based on the information you are given by the plan administrator. If you are an individual contributor, the information you are given by the plan administrator is based on the information you are given by the plan administrator.

- 8** Benefit and contribution bases:
- a**  Death benefit
  - b**  Disability
  - c**  Pension
  - d**  Life insurance
  - e**  Long-term disability benefits
  - f**  Accidental death
  - g**  Supplemental annuity
  - h**  Prescription drug
  - i**  Short-term disability
  - j**  FICA taxes
  - k**  Other taxes
  - l**  Indemnity
  - m**  Other benefits

**9** Experienced contracts:

<b>a</b> Pre-1981 contracts	9a(1)	
Increase/decrease in annual contribution	9a(2)	
Increase/decrease in the fixed reserve	9a(3)	
Contracted (1) (2) (3)	9a(4)	
<b>b</b> Benefit bases of contracts	9b(1)	
Increase/decrease in the reserve	9b(2)	
Inferred basis add (1) and (2)	9b(3)	
Contracts covered	9b(4)	
<b>c</b> Reimbursement or retention bases in the contract		
Commissions	9c(1)(A)	
Board/insurable service or other fees	9c(1)(B)	
Contract administration costs	9c(1)(C)	
Other expenses	9c(1)(D)	
Other	9c(1)(E)	
FICA taxes or risks or other contingencies	9c(1)(F)	
Other retention	9c(1)(G)	
Dividends or retrospective rate refunds (if any) were paid in cash or credited	9c(1)(H)	
<b>d</b> Status of reserve	9d(1)	
Contract reserves	9d(2)	
Other reserves	9d(3)	
<b>e</b> Dividends or retrospective rate refunds due to nonparticipating contract	9e	

**10** Nonexperienced contracts:

<b>a</b> Contract or subscription bases of carrier	10a	54532
<b>b</b> If the carrier, service, or other organization incurred any special costs in connection with the contract or retention of the contract, other than reported in part, line 2 above, report such costs	10b	

**Part IV Provision of Information**

- 11** Did the insurance policy provide any information necessary to complete Schedule F?  Yes  No
- 12** If the answer to line 11 is "Yes," specify the information not provided. ▶

**SCHEDULE C  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of the Treasury  
Employee Benefits Security Administration  
Pension Benefits Security Administration

**Service Provider Information**

This schedule is required to be filed under section 101 of the Employee Retirement Income Security Act of 1974 (ERISA).

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

OMB 1545-0047

**2023**

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

For the calendar year 2023 or its equivalent year beginning **08/01/2023**

and ending **07/31/2024**

**A** Name of the plan  
**DOMINO MANAGEMENT SERVICES LLC LIFE & DISABILITY PLAN**

**B** Record ID  
Plan number **501**

**C** Plan sponsor's name as shown on line 2a of Form 5500  
**DOMINO MANAGEMENT SERVICES LLC**

**D** Employer Identification Number  
**16-1642585**

**Part I Service Provider Information (see instructions)**

You must file this form in accordance with the instructions, regardless in what form required for each person was received, directly or indirectly, \$5,000 or more in compensation (including any or any other fee or charge) for any services rendered to the plan or the person's position during the plan year. If a person received only eligible indirect compensation or if the person received the required disclosures, you are required to answer line 1 unless notified otherwise in the instructions.

**1 Information on Persons Receiving Only Eligible Indirect Compensation**

**a** Check "Yes" or "No" to indicate whether you are excluding persons from the required disclosures they received only eligible indirect compensation or if the person 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. Check the box if any entries as needed (see instructions).

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

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

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

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

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**(b)** Enter name and title or address of persons who provided you with sources of information

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**(b)** Enter name and title or address of persons who provided you with sources of information

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**(b)** Enter name and title or address of persons who provided you with sources of information

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**(b)** Enter name and title or address of persons who provided you with sources of information

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**(b)** Enter name and title or address of persons who provided you with sources of information

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**(b)** Enter name and title or address of persons who provided you with sources of information

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**(b)** Enter name and title or address of persons who provided you with sources of information

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**(b)** Enter name and title or address of persons who provided you with sources of information

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**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** If 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 compensation during the year for any services rendered to the plan or their position with the plan during the year. See instructions.

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

CIGNA HEALTH AND LIFE INSURANCE COM

6625 W 78TH ST 260  
#280  
MINNEAPOLIS, MN 55439

59-1031071

(b) Service Codes	(c) Relationship employer, employee, contractor, or person in which the plan has an interest	(d) Enter direct compensation paid by the plan during the year	(e) Did service provider receive indirect compensation sources other than plan or plan sponsors	(f) Did indirect compensation include either indirect compensation, or did the plan receive the required disclosures	(g) Enter indirect compensation received by service provider excluding either indirect compensation or if you answered "Yes" to element 1 through, enter 0	(h) Did the service provider file you or or instead on in which estimated plan
12 13 31 38 49 50 56 62	SERVICE PROVIDER	2226	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

(b) Service Codes	(c) Relationship employer, employee, contractor, or person in which the plan has an interest	(d) Enter direct compensation paid by the plan during the year	(e) Did service provider receive indirect compensation sources other than plan or plan sponsors	(f) Did indirect compensation include either indirect compensation, or did the plan receive the required disclosures	(g) Enter indirect compensation received by service provider excluding either indirect compensation or if you answered "Yes" to element 1 through, enter 0	(h) Did the service provider file you or or instead on in which estimated plan
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(b) Service Codes	(c) Relationship employer, employee, contractor, or person in which the plan has an interest	(d) Enter direct compensation paid by the plan during the year	(e) Did service provider receive indirect compensation sources other than plan or plan sponsors	(f) Did indirect compensation include either indirect compensation, or did the plan receive the required disclosures	(g) Enter indirect compensation received by service provider excluding either indirect compensation or if you answered "Yes" to elemen 1 through, enter 0	(h) Did the service provider file you or or instead on in which estimated plan
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**Part I Service Provider Information (continued)**

3. If you reported on line 2 received indirect compensation, other than either indirect compensation, by a service provider, and the service provider is a fiduciary or provides administrative, consulting, advisory, investment, or recordkeeping services, answer the questions for the service provider that received 1,000 or more in indirect compensation and the service provider was used to determine the indirect compensation included on your estate tax return for the indirect compensation Code as any entries is needed to determine the required information for the service provider.

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

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

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

**Part II Service Providers Who Fail or Refuse to Provide Information**

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

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

<b>Part III</b>	<b>Termination Information on Accountants and Enrolled Actuaries (see instructions)</b> <small>Enter the name of any entries needed.</small>
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<b>a</b> Name	<b>b</b> EIN
<b>c</b> Position	
<b>d</b> Address	<b>e</b> Telephone

Continuation

<b>a</b> Name	<b>b</b> EIN
<b>c</b> Position	
<b>d</b> Address	<b>e</b> Telephone

Continuation

<b>a</b> Name	<b>b</b> EIN
<b>c</b> Position	
<b>d</b> Address	<b>e</b> Telephone

Continuation

<b>a</b> Name	<b>b</b> EIN
<b>c</b> Position	
<b>d</b> Address	<b>e</b> Telephone

Continuation

<b>a</b> Name	<b>b</b> EIN
<b>c</b> Position	
<b>d</b> Address	<b>e</b> Telephone

Continuation