Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024

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

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

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

D Check box if filing under:
- [ ] 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
WISCONSIN MANUFACTURERS & COMMERCE, INC. MANAGED ST DISABLITY PLAN

1b Three-digit plan number (PN) ▶ 506

1c Effective date of plan 06/01/1994

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
WISCONSIN MANUFACTURERS & COMMERCE, INC.

501 E WASHINGTON AVE
MADISON, WI 53703

2b Employer Identification Number (EIN) 39-1233219

2c Plan Sponsor's telephone number 608-258-3400

2d Business code (see instructions) 541990

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	04/22/2025	KURT BAUER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

WMC SERVICE CORPORATION

501 E. WASHINGTON AVE
MADISON, WI 53703-2914

3b Administrator's EIN
39-1413901

3c Administrator's telephone number
608-258-3400

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name

c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	4984
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	4984
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	0
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	0
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4F

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- **(4)** [ ] **DCG** (Individual Plan Information) – Number Attached _____
- **(5)** [ ] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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_____

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 10/01/2023 and ending 09/30/2024

A Name of plan
WISCONSIN MANUFACTURERS & COMMERCE, INC. MANAGED ST DISABLITY PLAN

B Three-digit plan number (PN) ▶ 506

C Plan sponsor's name as shown on line 2a of Form 5500
WISCONSIN MANUFACTURERS & COMMERCE, INC.

D Employer Identification Number (EIN)
39-1233219

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
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
13-5581829	65978	TS0538131	3239	10/01/2023	09/30/2024

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.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
76165	2940

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

R&R INSURANCE SERVICES INC
N14W23900 STONE RIDGE DR
WAUKESHA, WI 53186

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
14919			3

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

HAYS COMPANIES INC
1200 N MAYFAIR RD STE 100
MILWAUKEE, WI 53226

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
7487	821		3

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

ACRISURE LLC D/B/A HNI RISK SERVICE
16805 W CLEVELAND AVE
NEW BERLIN, WI 53151

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
6877			3

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

M3 INS SOLUTIONS INC
828 JOHN NOLEN DR
MADISON, WI 53713

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
6699			3

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

BENECO OF WISCONSIN INC
250 N PATRICK BLVD STE 100
BROOKFIELD, WI 53045

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
5275	52		3

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

T I C INC
701 SAND LAKE RD
ONALASKA, WI 54650

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
5297			3

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

HUB INTERNATIONAL MIDWEST LIMITED
2120 PEWAUKEE RD STE 202
WAUKESHA, WI 53188

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
4585			3

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

USI INS SERVICES LLC

PO BOX 62817
VIRGINIA BEACH, VA 62817

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
4116	299		3

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

MARSH & MCLENNAN AGENCY LLC

2725 S MOORLAND RD
NEW BERLIN, WI 53151

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
3729			3

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

VIZANCE INC

1320 WALNUT RIDGE DR STE 200
HARTLAND, WI 53029

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2326			3

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

JAMES R NELLIGAN & ASSOCIATES LLC

1933 STATE ROUTE 35 STE 368
WALL, NY 07719

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2009	278		3

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

JA COUNTER ASSOCIATES INC

PO BOX 387
NEW RICHMOND, WI 54017

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1784	142		3

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

BENEFITS INC
250 N PATRICK BLVD STE 100
BROOKFIELD, WI 53045

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1718			3

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

ROBERTSON RYAN & ASSOCIATION, INC.
330 E. KILBOURN AVE STE 650
MILWAUKEE, WI 53202

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1616			3

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

WMC SERVICE CORPORATION
501 E WASHINGTON AVE
MADISON, WI 53703

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1247			3

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

SYMPHONY RISK SOLUTIONS INSURANCE
101 MONTGOMERY ST STE 800
SAN FRANCISCO, CA 94104

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1134			3

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

HORTON GROUP INC
10320 ORLAND PKWY
ORLAND PARK, IL 60467

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1099			3

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

DARRELL ZALESKI D/B/A SPECTRUM BENE
318 N BRIDGE ST
CHIPPEWA FALLS, WI 54729

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
942			3

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

RSC INSURANCE BROKERAGE, INC
1103 HUNTER DR STE 100
MOUNT PLEASANT, WI 53406

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
779	5		3

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

ACRISURE LLC D/B/A GARCEAU INSURANC
PO BOX 1788
GRAND RAPIDS, ME 49501

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
	742		3

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

ANSAY & ASSOCIATES LLC
2901 W BELTLINE HWY STE 202
MADISON, WI 53713

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
736			3

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

CYGANIAK PLANNING, INC.
3515 N 124TH ST, STE 100
BROOKFIELD, WI 53005

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
622			3

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

DIGITAL INS INC

200 GALLERIA PKWY SE STE 1950
ATLANTA, GA 30342

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
386	35		3

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

BROWN & BROWN INSURANCE SERVICES IN

901 MARQUETTE AVE
MINNEAPOLIS, MN 55402

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
319			3

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

MARSH & MCLENNAN

250 PEHLE AVE STE 400
SADDLE BROOK, NJ 07663

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
	317		3

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

HUB INTERNATIONAL

16253 COLLECTION CENTER DR
CHICAGO, IL 60693

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
	249		3

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

SPECTRUM BENEFIT SOLUTIONS OF CENTR

903 GRAND AVE STE A-1
ROTHSCHILD, WI 54474

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
245			3

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

BUSINESS BENEFIT SOLUTIONS INC
PO BOX 158
CENTER CITY, MN 55012

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
131			3

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

MEYER INSURANCE AGENCY
511 PHILLIPS BLVD
SAUK CITY, WI 53583

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
71			3

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

JOHNSON INSURANCE SERVICES LLC
1103 HUNTER DRIVE
MOUNT PLEASANT, WI 53406

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
17			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	

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee 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** [X] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	811029
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2023** **This Form is Open to Public Inspection.**

For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024

A Name of plan	**B** Three-digit plan number (PN) ▶	
WISCONSIN MANUFACTURERS & COMMERCE, INC. MANAGED ST DISABLITY PLAN		506
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
WISCONSIN MANUFACTURERS & COMMERCE, INC.	39-1233219	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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)

WMC SERVICE CORPORATION

501 E WASHINGTON AVE
MADISON, WI 53703-2914

39-1413901

(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?
14	PLAN SPONSOR	102704	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

(complete as many entries as needed)

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210 - 0110
1210 - 0089

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024

A This return/report is for: ☐ a multiemployer plan ☒ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)

B This return/report is: ☐ 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)

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
WISCONSIN MANUFACTURERS & COMMERCE, INC.
MANAGED ST DISABLITY PLAN

1b Three-digit plan number (PN) ▶ 506

1c Effective date of plan 06/01/1994

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
WISCONSIN MANUFACTURERS & COMMERCE, INC.

501 E WASHINGTON AVE

MADISON WI 53703

2b Employer Identification Number (EIN) 39-1233219

2c Plan Sponsor's telephone number (608) 258-3400

2d Business code (see instructions) 541990

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

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

SIGN HERE	[signature]	4.22.25	KURT BAUER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2023)
v. 230728

318401 11-21-23

Employer TIN: WMC 39-1233219	Group Name
39-1029653	ACOUSTECH SUPPLY, INC.
26-0103327	AIM TRANSFER & STORAGE, INC.
39-0890906	ALADDIN ENGINEERING & MFG., IN
39-1588466	ALLIANCE PLASTICS CORPORATION
39-1402341	ALMON, INC.
39-1633320	AMALGA COMPOSITES, INC.
39-1565352	APPLEWOOD DRYWALL SERVICE, INC
39-0959492	AYERS FURNITURE COMPANY
39-1628642	BENTLEY WORLD-PACKAGING, LTD.
39-1650699	CAPITAL DATA
30-0111995	CARL STAHL AMERICAN LIFTING, LLC
39-1039812	COMET, INC.
39-1417808	CRAFTED PLASTICS INC.
39-1593017	GENERAL PLASTICS, INC.
39-1147571	GOODWILL INDUSTRIES OF SOUTH CENTRAL WISCONSIN, INC.
39-1869341	H & H INSURANCE SERVICES, INC.
39-1950751	HOUSEMAN & FEIND, L.L.P.
39-1533534	HY-TEST SAFETY SHOE SERVICE
39-1860978	IMPERIAL TECHNOLOGY, INC.
20-4397792	INTEGRITY GRADING & EXCAVATING, INC.
20-4976907	ITASCA AUTOMATION SYSTEMS, LLC
39-1176457	KAPCO, INC.
39-1250937	KDV LABEL CO., INC.
39-1310547	KEEL MANUFACTURING, INC.
36-2707870	KLEIN-DICKERT MILWAUKEE
37-1577945	KSM INDUSTRIES, INC.
45-3765821	KSP GROUP, INC.
39-0417440	Lakeside Bottling Company
39-0866468	LANGE BROS. WOODWORK CO., INC.
39-0972019	MACHINE INDUSTRIES, INC.
39-1213322	Marchant Schmidt
39-0988780	MERRILL IRON & STEEL, INC.
39-1982857	MID-STATE CONTRACTING, LLC
39-1023152	MITOTEC PRECISION
20-4685072	NEUROTECH, LLC
39-1052724	NEW HOPE CENTER, INC.
39-1134562	NORTHWEST BUILDERS, INC.
90-0669710	NOVA COIL, INC.
83-0736638	O'DONNELL'S TRUCK & BODY, INC.
39-1178876	PACKAGING SPECIALTIES, INC.
39-1136467	PACKERLAND RENT-A-MAT, INC.
39-1191616	PRIMEX, INC.
39-1570779	PRO SAFETY, INC.
39-1245558	RICHARD D. DAVENPORT M.D. & ASSOCIATES, S.C.
39-1023636	RYAN MANUFACTURING, INC.
39-1438368	Sauk Prairie Area Chamber of Commerce, Inc.
39-1222938	SEEK CAREERS/STAFFING, INC.
20-3131434	STELLANA U.S.
39-0885600	STURGEON BAY METAL PRODUCTS, INC.
39-1482987	TELLURIAN, INC.
39-1045976	TOEPFER SECURITY CORPORATION
39-1125465	ULTRA TOOL & MANUFACTURING
39-1041199	USEMCO, INC.
39-1965476	VILLANI LANDSHAPERS LAWN & LANDSCAPE MAINTENANCE
39-1936402	WAUKESHA AREA CONVENTION & VISITORS BUREAU, INC.
39-0689805	WAUKESHA COUNTY BUSINESS ALLIANCE, INC.
39-1273248	Waukesha Free Clinic
39-1610956	WISCONSIN METAL PARTS, INC.
39-1175385	ZENAR CORPORATION
39-1964259	Zoomlion Heavy Industry
83-1597865	Phoenix Products LLC