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

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

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.)
- ☒ a single-employer plan
- ☐ a DFE (specify) ____

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

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

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

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ ☐

Part II Basic Plan Information—enter all requested information

1a Name of plan
ADVANTMED WELFARE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 10/01/2021

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)
ADVANTMED, LLC

17981 SKYPARK CIRCLE, SUITE BC
IRVINE, CA 92614

17981 SKYPARK CIRCLE, SUITE BC
IRVINE, CA 92614

2b Employer Identification Number (EIN) 32-0453942

2c Plan Sponsor's telephone number 877-896-7350

2d Business code (see instructions) 561490

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.	04/25/2025	TRINA SCHNAPP
	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 [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

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

a Sponsor's name

c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	198
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)**	198
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	110
b	Retired or separated participants receiving benefits	**6b**	3
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	113
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	113
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

4A 4B 4D 4F 4H 4Q

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] 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)** [X] 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 2
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

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

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ 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 2024 Form M-1 annual report. If the plan was not required to file the 2024 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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
ADVANTMED WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

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

D Employer Identification Number (EIN)
32-0453942

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

1 Coverage Information:

(a) Name of insurance carrier
PRINCIPAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
42-0127290	61271	1116917	254	01/01/2024	12/31/2024

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.

(a) Total amount of commissions paid	(b) Total amount of fees paid
21473	19872

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

DICKERSON EMPLOYEE BENEFITS

AN ALGERA GROUP AGENCY
333 N GLENOAKS BLVD, SUITE 410
BURBANK, CA 91502-3273

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	8998	OVERRIDE	3

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

HUB INTERNATIONAL LIMITED

150 N RIVERSIDE PLAZA, SUITE 1700
CHICAGO, IL 60606-1572

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

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

STUMM INSURANCE, LLC

9400 W HIGGINS RD, SUITE 310
ROSEMONT, IL 60018-4975

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
21473	10094	BONUS	3

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

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

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

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

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

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

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

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

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)**	
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** [X] Dental
- **c** [X] Vision
- **d** [X] Life insurance
- **e** [X] Temporary disability (accident and sickness)
- **f** [X] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [X] PPO contract
- **l** [ ] Indemnity contract
- **m** [X] Other (specify) ▶ CRITICAL ILLNESS, ACCIDENT

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)	0
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	191228
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
ADVANTMED WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

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

D Employer Identification Number (EIN)
32-0453942

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
UNITEDHEALTHCARE 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
36-2739571	79413	07X5092	104	01/01/2024	12/31/2024

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.

(a) Total amount of commissions paid	(b) Total amount of fees paid
47197	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

EMERSON ROGERS LLC CALIFORNIA
669 RIVER DRIVE CENTER II, STE 305
ELMWOOD PARK, NJ 07407

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
12042			3

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

ROGERS BENEFITS GROUP INC. - CA
669 RIVER DRIVE CENTER II STE 305
ELMWOOD PARK, NJ 07407

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
6111			3

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

STUMM INSURANCE LLC

9400 W HIGGINS RD, SUITE 310
ROSEMONT, IL 60018-4975

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
29044			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	

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)**	
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** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] 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**	665341
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. ▶

March 28, 2025

ADVANTMED LLC DBA RECORDFLOW
17981 SKY PARK CIRCLE, SUITE BC
IRVINE, CA 92614

Dear Valued Customer:

Employee Retirement Income Security Act of 1974 (ERISA)

We have enclosed information that you may need for completing the 5500 Form Schedule A. This information reflects compensation paid to your agent or consultant for the plan year that recently ended for the coverages you have with us.

We are reporting any base commissions, bonuses and other types of compensation paid in relation to the plan during the plan year. Please note that only base commissions are included in the specific calculation of your premium or administrative service fee. Bonus and other non-base commission payments are not directly included in the determination of your premium or administrative service fee. Bonus payments may be based on the recipient's combined block of business and are allocated to cases according to their contribution to the amount earned.

IMPORTANT NOTE: The enclosed information may be divided into two reports. Some customers may receive a 5500 Addendum Report in addition to the standard 5500 Schedule A report form. The 5500 Addendum Report itemizes bonus compensation and payments that were processed manually separately. **If you have received the 5500 Addendum Report as well as the standard 5500 Schedule A report form, you will need to add the amounts in the Total line of the 5500 Addendum Report to the amount found in the standard 5500 Schedule A report form.**

Should you have any questions related to this information, please contact your agent, consultant, or the UnitedHealthcare Strategic Account Executive assigned to your case.

I hereby certify that to the best of my knowledge, information or belief at this time, and based upon information provided by duly authorized personnel, the foregoing statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate.

Thank you.

Sincerely,
The United Healthcare Team

Schedule A (Form 5500) Parts I and III
Insurance Information Certified by Carrier
Department of Labor Pension and Welfare Benefits

Principal Address:
17981 SKY PARK CIRCLE, SUITE BC

IRVINE, CA 92614

A Name of Plan: ADVANTMED LLC DBA RECORDFLOW

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

1. Coverage

(a) Name of Insurance carrier: UnitedHealthcare Insurance Company

(b) EIN: 36-2739571 (c) NAIC code: 79413 (d) Contract or identification number: 07X5092

(e) Approximate number of persons covered at the end of policy or contract year: * 104

*** If the policy holder determines that they have a more accurate count, they should use their figure.**

Policy or Contract year (f) From: January 1, 2024 (g) To: December 31, 2024

2. Insurance fees and commissions paid to agents, brokers, and other persons

Totals Total amount of commissions Paid: $47,197.33 **Total fees paid / amount: $0.00**

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid:

EMERSON ROGERS LLC CALIFORNIA

669 RIVER DRIVE CENTER II SUITE 305
ELMWOOD PARK, NJ 07407-

(b) Amount of commissions paid: $12,041.70 (c) Fees paid / Amount: NONE (d) Fees paid / Purpose: N/A
(e) Organizational Code: 3

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid:

ROGERS BENEFIT GROUP INC - CALIFORNIA

669 RIVER DRIVE CENTER II SUITE 305
ELMWOOD PARK, NJ 07407-

(b) Amount of commissions paid: $6,111.13 (c) Fees paid / Amount: NONE (d) Fees paid / Purpose: N/A
(e) Organizational Code: 3

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid:

STUMM INSURANCE LLC

9400 W HIGGINS RD STE 310
ROSEMONT, IL 60018-4975

(b) Amount of commissions paid: $29,044.50 (c) Fees paid / Amount: NONE (d) Fees paid / Purpose: N/A
(e) Organizational Code: 3

Part III Welfare Benefit Contract Information

7. Benefit and contract type
(a) Health

9. Non experience-rated contracts:
(a) Total premiums or subscription charges paid to carrier: $665,340.68

(b) Additional costs incurred by carrier, service, or other

Organization not reported in Part 1, item 2 above:

Specify Nature of cost:

Sue Behrle-Lulow
Ops Support Analyst
Behrle-Lulow.Sue@principal.com

Workplace Benefits Solutions
Principal Life Insurance Company
711 High Street
Des Moines, IA 50392-5120

919 A44060

Principal®

March 6, 2025

ADVANTMED LLC
DAVEN PATEL
17981 SKY PARK CIR STE BC
IRVINE CA 92614

DICKERSON EMPLOYEE BENEFIS AN
ALERA GROUP AGENCY L
333 N GLENOAKS BLVD STE 410
BURBANK CA 91502-3273

Re Acct No. 1116917 Anniversary Date: January 1, 2025

We thank you for selecting Principal for your insurance needs.

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

We've enclosed your Schedule A Insurance Information ***worksheet*** for the period January 1, 2024 through December 31, 2024 to assist you with your filing of the Schedule A (Form 5500). The paid premium reported on the Schedule A worksheet represents premium received and applied to your account during the reported period. This information will need to be transferred to a Schedule A template.

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

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

The Department of Labor requires filings to be submitted electronically at www.efast.dol.gov.

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

A copy of the enclosed Schedule A Insurance Information worksheet will also be available online through the Employer Web link at www.principal.com. For assistance with enrolling in the Employer Web Service, policyholders can call the Principal's Employer Group Plan Customer Service at 1-800-843-1371. Brokers, please contact our Advisor Web Support Team at 1-800-554-3395.

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

Enclosure

Contract # 1116917
Name of Plan ADVANTMED LLC
Data Period January 1, 2024 to December 31, 2024

Principal®

Principal Life Insurance Company
Schedule A (Form 5500) Worksheet

Section 1: Coverage

(a) Name of Insurance Carrier	(b) EIN	(c) NAIC Code
Principal Life Insurance Company	42-0127290	61271

(d) Contract or Id Number	1116917	Approx. no. of Persons cov. At End of Policy Year	Total (e)	254
Combined Numbers			Employees	170
			Dependents	84

Policy or Contract Year From **(f)** January 1, 2024 To **(g)** December 31, 2024

Section 2: Insurance fee and commissions information

	(a) Commissions Paid	(b) Fees Paid
Total (from below)	21,473	19,872

Section 3: Persons receiving commissions and fees

(a) Name & Address of Agents or Brokers to whom Commissions or Fees Paid	(b) Amount of Commissions Paid	Fees Paid (c) Amount / (d) Purpose	(e) Org Code
DICKERSON EMPLOYEE BENEFIS AN ALERA GROUP AGENCY 333 N GLENOAKS BLVD STE 410 BURBANK CA 91502-3273		8,998 * Override	3 - Ins Agent or Broker
HUB INTERNATIONAL LIMITED 150 N RIVERSIDE PLZ STE 1700 CHICAGO IL 60606-1572		780 * Bonus	3 - Ins Agent or Broker
STUMM INSURANCE, LLC 9400 W HIGGINS RD STE 310 ROSEMONT IL 60018-4975	21,473	10,094 * Bonus	3 - Ins Agent or Broker

Reportable commissions and fees include all forms of compensation directly or indirectly attributable to your Principal Life Insurance Company policies.
** This part of the compensation amount reflects a portion of administrative expenses that are allocated across all policies sold by PLIC. It is not part of your actual cost.*

Section 8: Benefit and Contract Type

(a)	Health *(other than dental or vision)*	(b) X	Dental	(c) X	Vision	(d) X	Life Ins.
(e) X	Temporary Disability (accident and sickness)	(f) X	Long Term Disability	(g)	Supplemental Unemployment	(h)	Prescription Drug
(i)	Stop Loss (large deductible)	(j)	HMO Contract	(k) X	PPO Contract	(l)	Indemnity Contract
(m) X	Other: Critical Illness, Accident						

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

Section 10: Non-Experience Rated Contracts

(a) Total Premiums Paid to Carrier	191,228