

<p style="text-align: center;">Form 5500</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p style="font-size: x-small;">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).</p> <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; font-weight: bold; text-align: center;">2023</p> <hr/> <p style="text-align: center; font-weight: bold;">This Form is Open to Public Inspection</p>
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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 (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

<p>1a Name of plan <u>LOCAL 1964 ILA HEALTH & INSURANCE FUND</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>501</u></p>
<p>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) <u>LOCAL 1964 ILA HEALTH AND INSURANCE FUND</u></p> <p><u>11 TEANECK ROAD</u> <u>RIDGEFIELD PARK, NJ 07660</u></p>	<p>1c Effective date of plan <u>12/21/1972</u></p> <p>2b Employer Identification Number (EIN) <u>23-7248562</u></p> <p>2c Plan Sponsor's telephone number <u>201-440-6523</u></p> <p>2d Business code (see instructions) <u>484110</u></p>

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.	05/15/2025	BRIAN WALLACH
	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 <input checked="" type="checkbox"/> 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	1078
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 a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	1075
	6a(2)	1138
	6b	2
	6c	
	6d	1140
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7	25

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 4Q 4U

9a Plan funding arrangement (check all that apply)	9b 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 checked="" type="checkbox"/> Trust	(3) <input checked="" 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)

a Pension Schedules	b General Schedules
(1) <input type="checkbox"/> R (Retirement Plan Information)	(1) <input checked="" type="checkbox"/> H (Financial Information)
(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) <input type="checkbox"/> I (Financial Information – Small Plan)
(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>4</u>
(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____	(4) <input checked="" type="checkbox"/> C (Service Provider Information)
(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	(5) <input type="checkbox"/> D (DFE/Participating Plan Information)
	(6) <input type="checkbox"/> 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 **08/01/2023** and ending **07/31/2024**

A Name of plan LOCAL 1964 ILA HEALTH & INSURANCE FUND		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 1964 ILA HEALTH AND INSURANCE FUND		D Employer Identification Number (EIN) 23-7248562

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
RELIANCE STANDARD LIFE INSURANCE CO.

(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
36-0883760	68381	GL153554	929	01/01/2023	12/31/2023

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid 8727	(b) Total amount of fees paid 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
PROFESSIONAL GROUP PLANS, INC. 225 WIRELESS BLVD - STE 200 HAUPPAUGE, NY 11788

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5161			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MARK SPIVAK (THE WEISS GROUPO) 200 PARK AVE, 32ND FLR NEW YORK, NY 10166

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3566			4

(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.

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 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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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	103229
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 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

2023

This Form is Open to Public Inspection

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

A Name of plan LOCAL 1964 ILA HEALTH & INSURANCE FUND		B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 1964 ILA HEALTH AND INSURANCE FUND		D Employer Identification Number (EIN) 23-7248562	

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
RELIANCE STANDARD LIFE INSURANCE CO.

(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
36-0883760	68381	VAR 206484	929	01/01/2023	12/31/2023

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid 1720	(b) Total amount of fees paid 0
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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
**MARK SPIVAK (THE WEISS GROUPOU) 200 PARK AVE, 32ND FLR
NEW YORK, NY 10166**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1290			

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
**PROFESSIONAL GROUP PLANS, INC. 225 WIRELESS BLVD - STE 200
HAUPPAUGE, NY 11788**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
430			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	

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.
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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. Specify nature of costs ▶	6d	

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)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(2) Dividends and credits		
(3) Interest credited during the year		
(4) Transferred from separate account.....		
(5) Other (specify below)		
▶		
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
(1) Disbursed from fund to pay benefits or purchase annuities during year		
(2) Administration charge made by carrier		
(3) Transferred to separate account.....		
(4) Other (specify below)		
▶		
(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 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) ▶ **ACCIDENTAL DEATH & DISMEMBERMENT**

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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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	8602
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 No

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

<p>SCHEDULE A (Form 5500)</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>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</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>2023</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2023 or fiscal plan year beginning **08/01/2023** and ending **07/31/2024**

<p>A Name of plan LOCAL 1964 ILA HEALTH & INSURANCE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 1964 ILA HEALTH AND INSURANCE FUND</p>	<p>D Employer Identification Number (EIN) 23-7248562</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
SUN LIFE ASSURANCE COMPANY OF CANADA

(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
38-1082080	80802	216787	13	01/01/2023	12/31/2023

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

<p>(a) Total amount of commissions paid 660</p>	<p>(b) Total amount of fees paid 0</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
PROFESSIONAL GROUP PLANS, INC. 225 WIRELESS BLVD - STE 200 HAUPPAUGE, NY 11788

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
660			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
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(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)** 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** 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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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	3890
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 No

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

<p>SCHEDULE A (Form 5500)</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>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</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>2023</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2023 or fiscal plan year beginning **08/01/2023** and ending **07/31/2024**

<p>A Name of plan LOCAL 1964 ILA HEALTH & INSURANCE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 1964 ILA HEALTH AND INSURANCE FUND</p>	<p>D Employer Identification Number (EIN) 23-7248562</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
RELIANCE STANDARD LIFE INSURANCE CO.

(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
36-0883760	68381	GL153902	12	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 1014</p>	<p>(b) Total amount of fees paid 0</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
MARK SPIVAK (THE WEISS GROUPOU) 200 PARK AVE, 32ND FLR NEW YORK, NY 10166

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
697			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
PROFESSIONAL GROUP PLANS, INC. 225 WIRELESS BLVD - STE 200 HAUPPAUGE, NY 11788

(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

(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.
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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. Specify nature of costs ▶	6d	
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
f 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)

a 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 Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	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)	
	7e(2)	
	7e(3)	
	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 <input type="checkbox"/> Health (other than dental or vision) | b <input type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input checked="" type="checkbox"/> Life insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input type="checkbox"/> Indemnity contract |
| m <input checked="" type="checkbox"/> Other (specify) ▶ ACCIDENTAL DEATH & DISMEMBERMENT | | | |

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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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	6336
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 No

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

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider 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.	<small>OMB No. 1210-0110</small> 2023 This Form is Open to Public Inspection.
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For calendar plan year 2023 or fiscal plan year beginning **08/01/2023** and ending **07/31/2024**

A Name of plan LOCAL 1964 ILA HEALTH & INSURANCE FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 1964 ILA HEALTH AND INSURANCE FUND	D Employer Identification Number (EIN) 23-7248562	

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

DOUBLELINE CAPITAL LP

30-0596331

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

THE VANGUARD GROUP INC

23-1945930

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

LOOMIS SAYLES AND COMPANY LP

04-3200030

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

WISDOMTREE ASSET MANAGEMENT INC

13-3487784

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

MASSACHUSETTS FINANCIAL SERVICES CO

04-2747644

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

ARTISAN PARTNERS

39-1807188

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

LORD ABBETT & CO LLC

13-5620131

(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)

HILDA SANCHEZ

23-7248562

(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?
30 50	EMPLOYEE	139681	Yes <input type="checkbox"/> No <input checked="" 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)

OPTIMUM TECHNOLOGIES INC

04-3283029

(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?
49 99 50	NONE	139200	Yes <input type="checkbox"/> No <input checked="" 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)

LORRAINE LEVY

23-7248562

(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?
30 50	EMPLOYEE	138044	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

MAGNACARE ADMINSTRATIVE SVCS LLC

11-3410766

(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?
34 50	NONE	129690	Yes <input type="checkbox"/> No <input checked="" 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)

FRANCA EUVINO

23-7248562

(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?
30 50	EMPLOYEE	115675	Yes <input type="checkbox"/> No <input checked="" 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)

RICHARD GALLO

23-7248562

(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?
30 50	EMPLOYEE	110293	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

UNITED LABOR SYSTEMS

360 E PARK AVE
LONG BEACH, NY 11561

(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?
15 50	NONE	109225	Yes <input type="checkbox"/> No <input checked="" 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)

PRICILLA POVEDA GARCIA

23-7248562

(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?
30 50	EMPLOYEE	102650	Yes <input type="checkbox"/> No <input checked="" 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)

RELIANCE TRUST COMPANY

58-1428634

(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?
19 28 50	NONE	100831	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

ADAM HARRIS

23-7248562

(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?
30 50	EMPLOYEE	98901	Yes <input type="checkbox"/> No <input checked="" 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)

DAVID HARRIS

23-7248562

(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?
30 50	EMPLOYEE	92582	Yes <input type="checkbox"/> No <input checked="" 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)

EVELYN DEJESUS GUTIERREZ

23-7248562

(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?
30 50	EMPLOYEE	83419	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

FLORENCE SACINO

23-7248562

(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?
30 50	EMPLOYEE	70659	Yes <input type="checkbox"/> No <input checked="" 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)

BENECARD SERVICES, INC.

22-2998772

(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?
13 50	NONE	69487	Yes <input type="checkbox"/> No <input checked="" 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)

MIRANDA TYNER

23-7248562

(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?
30 50	EMPLOYEE	63449	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

MARIA ORTIZ

23-7248562

(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?
30 50	EMPLOYEE	55802	Yes <input type="checkbox"/> No <input checked="" 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)

NOVAK FRANCELLA LLC

61-1436956

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	49591	Yes <input type="checkbox"/> No <input checked="" 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)

DR STEPHEN JAFFE

16 LANCASTER RD
TENAFLY, NJ 07670

(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?
70 50	NONE	41600	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

ERIC M. HARRIS, ESQ., P.C.

485 UNDERHILL BLVD, STE 203
SYOSSET, NY 11791

(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?
29 50	NONE	36000	Yes <input type="checkbox"/> No <input checked="" 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)

NANCY BONSANTI

23-7248562

(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?
30 50	EMPLOYEE	30570	Yes <input type="checkbox"/> No <input checked="" 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)

UNITED HEALTHCARE SERVICES, INC.

41-1289245

(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?
13 50	NONE	25403	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

HEALTHPLEX INC

11-2714365

(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?
13 50	NONE	17290	Yes <input type="checkbox"/> No <input checked="" 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)

BACK NINE CONSULTING, LLC

41 DUNBAR ROAD
PALM BEACH GARDENS, FL 33418

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 50	NONE	12700	Yes <input type="checkbox"/> No <input checked="" 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)

PNG CYBER, LLC

1 SUGAR CREEK CENTER BLVD, STE 1100
SUGAR LAND, TX 77478

(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?
49 99 50	NONE	6095	Yes <input type="checkbox"/> No <input checked="" 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.

(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:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2023 This Form is Open to Public Inspection
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For calendar plan year 2023 or fiscal plan year beginning 08/01/2023 and ending 07/31/2024	
A Name of plan LOCAL 1964 ILA HEALTH & INSURANCE FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 1964 ILA HEALTH AND INSURANCE FUND	D Employer Identification Number (EIN) 23-7248562

Part I	Asset and Liability Statement
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1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets	(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a 1000	26535
b Receivables (less allowance for doubtful accounts):		
(1) Employer contributions	1b(1) 467503	517492
(2) Participant contributions	1b(2)	
(3) Other	1b(3) 141847	181330
c General investments:		
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1) 5790566	4193417
(2) U.S. Government securities	1c(2) 5265516	6030181
(3) Corporate debt instruments (other than employer securities):		
(A) Preferred	1c(3)(A)	
(B) All other	1c(3)(B) 2109945	2772920
(4) Corporate stocks (other than employer securities):		
(A) Preferred	1c(4)(A) 3616496	887582
(B) Common	1c(4)(B)	
(5) Partnership/joint venture interests	1c(5)	
(6) Real estate (other than employer real property)	1c(6)	
(7) Loans (other than to participants)	1c(7)	
(8) Participant loans	1c(8)	
(9) Value of interest in common/collective trusts	1c(9)	
(10) Value of interest in pooled separate accounts	1c(10)	
(11) Value of interest in master trust investment accounts	1c(11)	
(12) Value of interest in 103-12 investment entities	1c(12)	
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13) 15452772	20691573
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	
(15) Other	1c(15)	

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e	24402	50513
f Total assets (add all amounts in lines 1a through 1e)	1f	32870047	35351543
Liabilities			
g Benefit claims payable	1g	538981	481801
h Operating payables	1h	39226	23750
i Acquisition indebtedness	1i		
j Other liabilities	1j	106327	52625
k Total liabilities (add all amounts in lines 1g through 1j)	1k	684534	558176
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	32185513	34793367

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	5849389	
(B) Participants	2a(1)(B)	6660	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		5856049
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	159103	
(B) U.S. Government securities	2b(1)(B)	171634	
(C) Corporate debt instruments	2b(1)(C)	99797	
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		430534
(2) Dividends:			
(A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)	73877	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	628305	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		702182
(3) Rents	2b(3)		37151
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds	2b(4)(A)	18489582	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	18141653	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		347929
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	235432	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		235432

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts.....	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts.....	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities.....	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		1428444
c Other income	2c		234
d Total income. Add all income amounts in column (b) and enter total	2d		9037955

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	4367649	
(2) To insurance carriers for the provision of benefits.....	2e(2)	111431	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		4479080
f Corrective distributions (see instructions).....	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances.....	2i(1)	1197418	
(2) Contract administrator fees.....	2i(2)		
(3) Recordkeeping fees.....	2i(3)		
(4) IQPA audit fees.....	2i(4)	49591	
(5) Investment advisory and investment management fees	2i(5)	104831	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	12700	
(8) Legal fees	2i(8)	37238	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	549243	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		1951021
j Total expenses. Add all expense amounts in column (b) and enter total	2j		6430101

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		2607854
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) Unmodified (2) Qualified (3) Disclaimer (4) Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d) (3) neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **NOVAK FRANCELLA, LLC**

(2) EIN: **61-1436956**

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) This form is filed for a CCT, PSA, DCG or MTIA. (2) It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.).....		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.).....		X	
e Was this plan covered by a fidelity bond?.....	X		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?.....		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.).....	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.).....	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.).....		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		X	

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?..... Yes No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

**LOCAL 1964 I.L.A.
HEALTH AND INSURANCE FUND**

FINANCIAL STATEMENTS

JULY 31, 2024

**LOCAL 1964 I.L.A.
HEALTH AND INSURANCE FUND**

FINANCIAL STATEMENTS WITH SUPPLEMENTAL INFORMATION

JULY 31, 2024 AND 2023

CONTENTS

	PAGE
Independent Auditor's Report	1
Statements of Net Assets Available for Benefits and Benefit Obligations	4
Statements of Changes in Net Assets Available for Benefits and Changes in Benefit Obligations	6
Notes to Financial Statements	8
Supplemental Information	
Schedules of Administrative Expenses	17
Schedule of Assets Held at End of Year	18
Schedule of Reportable Transactions	22

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of the
Local 1964 I.L.A.
Health and Insurance Fund

We have audited the financial statements of the Local 1964 I.L.A. Health and Insurance Fund (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and benefit obligations as of July 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and changes in benefits obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and benefit obligations of the Plan as of July 31, 2024 and 2023, and the changes in its net assets available for benefits and benefit obligations for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

Management is also responsible for maintaining a current plan instrument, including all Plan amendments; administering the Plan; and determining that the Plan's transactions that are presented and disclosed in the financial statements are in conformity with the Plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Report on Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental Schedule of Assets Held at End of Year, Schedule of Reportable Transactions and Schedules of Administrative Expenses, together referred to as “supplemental information,” are presented for the purpose of additional analysis and are not a required part of the financial statements. The supplemental Schedule of Assets Held at End of Year and Schedule of Reportable Transactions represent supplemental information required by the Department of Labor’s Rules and Regulations for Reporting and Disclosure under ERISA. Supplemental information is the responsibility of the Plan’s management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In forming our opinion on the supplemental information, we evaluated whether the supplemental information, including their form and content, are presented in conformity with the Department of Labor’s Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying schedules is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the Department of Labor’s Rules and Regulations for Reporting and Disclosure under ERISA.

Novak Francella LLC

New York, New York
May 7, 2025

**LOCAL 1964 I.L.A.
HEALTH AND INSURANCE FUND**

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS AND BENEFIT OBLIGATIONS

JULY 31, 2024 AND 2023

	2024	2023
NET ASSETS AVAILABLE FOR BENEFITS		
ASSETS		
INVESTMENTS - at fair value		
United States Government and Government		
Agency obligations	\$ 6,030,181	\$ 5,265,516
Corporate obligations	2,772,920	2,109,945
Common stock	887,582	3,616,496
Mutual funds and exchange traded funds	20,691,573	15,452,772
Short-term investments	2,121,031	2,718,947
Certificate of deposit	2,037,504	3,026,535
Total investments	34,540,791	32,190,211
RECEIVABLES		
Employer contributions	517,492	467,503
Prescription rebates	58,190	46,091
Accrued interest and dividends	60,519	44,771
Due from related entities	9,720	-
Total receivables	645,921	558,365
OTHER ASSETS		
Cash	61,417	46,084
Deposits	32,717	32,717
Prepaid expenses	20,184	18,268
Property and equipment - net	50,513	24,402
Total other assets	164,831	121,471
Total assets	35,351,543	32,870,047
LIABILITIES AND NET ASSETS		
LIABILITIES		
Securities purchased and not settled	52,625	22,317
Accrued expenses	23,750	39,226
Due to related entities	-	84,010
Total liabilities	76,375	145,553

See accompanying notes to financial statements.

	<u>2024</u>	<u>2023</u>
NET ASSETS AVAILABLE FOR BENEFITS	\$ 35,275,168	\$ 32,724,494
BENEFIT OBLIGATIONS		
Estimated claims payable, claims incurred but not reported and premiums due to insurer	<u>481,801</u>	<u>538,981</u>
EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS	<u><u>\$ 34,793,367</u></u>	<u><u>\$ 32,185,513</u></u>

See accompanying notes to financial statements.

**LOCAL 1964 I.L.A.
HEALTH AND INSURANCE FUND**

**STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
AND CHANGES IN BENEFIT OBLIGATIONS**

YEARS ENDED JULY 31, 2024 AND 2023

	2024	2023
NET CHANGE IN NET ASSETS AVAILABLE FOR BENEFITS		
ADDITIONS		
Investment income		
Net appreciation (depreciation) in fair value of investments	\$ 2,011,805	\$ (78,501)
Interest and dividends	1,132,716	921,143
	3,144,521	842,642
Less investment expenses	(104,831)	(155,697)
Investment income - net	3,039,690	686,945
Contribution income		
Employer contributions	5,849,389	5,608,879
COBRA contributions	6,660	7,326
Total contribution income	5,856,049	5,616,205
Other income	234	-
Total additions	8,895,973	6,303,150
DEDUCTIONS		
Cost of benefits		
Insured benefits		
Life	111,431	118,420
Self-insured benefits		
Medical	3,761,937	2,648,238
Prescription drugs	353,396	336,668
Dental	64,174	79,658
Administrative fees to provide benefits	245,322	245,685
Total cost of benefits	4,536,260	3,428,669
Government fees mandated by the Affordable Care Act	5,319	5,677
Administrative expenses	1,803,720	1,783,836
Total deductions	6,345,299	5,218,182
NET INCREASE IN NET ASSETS AVAILABLE FOR BENEFITS	2,550,674	1,084,968
NET CHANGE IN BENEFIT OBLIGATIONS		
Change during the year attributable to		
Estimated claims payable, claims incurred but not reported and premiums due to insurer	57,180	(108,354)

See accompanying notes to financial statements.

	<u>2024</u>	<u>2023</u>
EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS		
NET INCREASE	\$ 2,607,854	\$ 976,614
EXCESS		
Beginning of year	<u>32,185,513</u>	<u>31,208,899</u>
End of year	<u><u>\$ 34,793,367</u></u>	<u><u>\$ 32,185,513</u></u>

See accompanying notes to financial statements.

**LOCAL 1964 I.L.A.
HEALTH AND INSURANCE FUND**

NOTES TO FINANCIAL STATEMENTS

JULY 31, 2024 AND 2023

NOTE 1. DESCRIPTION OF THE PLAN

The following brief description of the Local 1964 I.L.A. Health and Insurance Fund (the Plan) provides only general information. Participants should refer to the Summary Plan Description for a more complete description of the Plan's provisions.

General -The Plan was adopted pursuant to the authority of the Board of Trustees granted under the Agreement and Declaration of Trust entered on August 3, 1970. The Plan provides health benefits covering employees of the employers that have collective bargaining agreements with the Local 1964 International Longshoremens' Association and are required to make contributions to the Plan pursuant to those agreements. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Benefits - The Plan provides hospitalization, major medical, prescription drug, dental, optical and life insurance benefits to eligible participants. The Plan also provides certain benefits to eligible spouses and dependents of participants. The Plan also provides continuation of certain benefits through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Insured Benefit - The Plan provides life insurance benefit, and accidental death and dismemberment benefit available to the participant only. Life insurance is not available to participant spouses or dependent children. For participants age 65 or over, the amount of the basic life insurance benefit is subject to automatic reduction.

Self-insured Benefits - All other Plan benefits are self-insured. The payment or reimbursement of claims for medical benefits for eligible participants and dependents are processed by the Plan. The Plan may make payments directly to the health-care provider if this is the request of the participant or eligible dependent. The payment of claims for prescription drugs and dental benefits is processed by a third-party claims processor under administrative services only contracts with the Plan.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Method of Accounting - The accompanying financial statements are prepared using the accrual basis of accounting.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Investment Valuation and Income Recognition - Investments are carried at fair value. The valuation for United States Treasuries, preferred stock, common stock, mutual and exchange traded funds are generally based on quoted market prices or the net asset value of the fund as of the last business day of the fiscal year as provided by the custodian. Government Agency obligations and corporate obligations are valued using pricing models that maximize the use of observable inputs for similar securities, including yields, credit ratings and brokers quotes, if available. The certificate of deposit is valued at original cost plus accrued interest, which approximates fair value. The short-term investment is valued at cost, which approximates fair value.

Purchases and sales are recorded on a trade basis. Interest and dividends are recorded on the accrual basis. Net appreciation includes the Plan's gains and losses on investments bought and sold, as well as held during the year.

Property and Equipment - Property and equipment are carried at cost. Major additions are capitalized while replacements, maintenance and repairs which do not improve or extend the lives of the respective assets are expensed currently. Depreciation expense is computed by the straight-line method over the estimated useful lives of the assets, which is generally 5 years for office equipment, 10 years for furniture and fixtures, 5 years for computer equipment and 20 years for leasehold improvements.

Depreciation expense allocated between the Health and Insurance Fund, the Local 1964 Retirement Fund, and the Local 1964 I.L.A. totaled \$10,264 for the year ended July 31, 2024 and \$8,232 for 2023.

Depreciation expense related solely to the Health and Insurance Fund totaled \$1,612 for the year ended July 31, 2024 and \$1,566 for 2023.

Employer Contributions - Employer contributions due but not paid at year end are recorded as contributions receivable. Allowance for credit losses is considered unnecessary and is not provided.

Securities Purchased or Sold and Not Settled - This represents the amount due to or from the custodial bank for the purchase or sale of securities with trade dates prior to year end and settlement dates after year end.

Benefit Payments - Benefit payments to or for participants are recorded when paid.

Refunds - The Plan utilizes a pharmacy benefit manager (PBM) which periodically makes refunds to the Plan based on the Plan's utilization pattern of specific drugs. Refunds due to the Plan are recorded when earned. Refunds due are reported as receivables, with the offset being netted with claims paid in the accompanying statements of changes in net assets available for benefits for the years ended July 31, 2024 and 2023.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.

NOTE 3. FUNDING POLICY

The Plan is financed by employer contributions and contributions from members electing COBRA coverage. Employer contributions are accounted for as exchange transactions. The employer contribution rates are specified in the various collective bargaining agreements.

The employer contribution rates in effect during the years ended July 31, 2024 and 2023, ranged from \$100 to \$752 per month, per participant.

NOTE 4. PRIORITIES UPON TERMINATION

It is the intent of the Trustees to continue the Plan in full force and effect; however, to safeguard against any unforeseen contingencies, the right to discontinue the Plan is reserved to the Trustees. In the event of termination, the Trustees shall first satisfy or make provisions to satisfy the obligations of the Plan. Any remaining Plan assets will be distributed in such manner as will, in the opinion of the Trustees, bring about the purpose of the Plan. Termination shall not permit any part of the Plan to be used for or diverted to purposes other than the exclusive benefit of the participants.

NOTE 5. TAX STATUS

The Plan obtained its latest exemption letter dated December 27, 1972, in which the Internal Revenue Service stated that the Plan, as then designed, was in compliance with applicable requirements of the Internal Revenue Code and was, therefore, exempt from federal income taxes under the provisions of Section 501(c)(9). The Plan has been amended since receiving the exemption letter. The Plan's Trustees and the Plan's counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that, more likely than not, would not be sustained upon examination by the U.S. Federal, state, or local taxing authorities.

The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Typically, plan tax years will remain open for three years; however, this may differ depending upon the circumstances of the Plan.

NOTE 6. FAIR VALUE MEASUREMENTS

The framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy are described as follows:

Basis of Fair Value Measurement:

Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2 - Inputs to the valuation methodology include: quoted prices for similar assets or liabilities in active markets; quoted prices for identical or similar assets or liabilities in inactive markets; inputs other than quoted prices that are observable for the asset or liability; inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or model-based valuation techniques may require the transfer of financial instruments from one fair value level to another. In such instances, the transfer is reported at the beginning of the reporting period.

For the years ended July 31, 2024 and 2023, there were no transfers in or out of levels 1, 2 or 3.

NOTE 6. FAIR VALUE MEASUREMENTS (continued)

The following tables set forth by level within the fair value hierarchy, the major categories of the Plan's assets measured at fair value as of July 31, 2024 and 2023:

	Fair Value Measurements at July 31, 2024			
	Total	Level 1	Level 2	Level 3
United States Government and Government Agency obligations	\$ 6,030,181	\$ 3,681,797	\$ 2,348,384	\$ -
Corporate obligations	2,772,920	-	2,772,920	-
Common stock	887,582	887,582	-	-
Mutual funds and exchange traded funds	20,691,573	20,691,573	-	-
Short-term investments	2,121,031	2,121,031	-	-
Certificate of deposit	2,037,504	2,037,504	-	-
	<u>\$ 34,540,791</u>	<u>\$ 29,419,487</u>	<u>\$ 5,121,304</u>	<u>\$ -</u>

	Fair Value Measurements at July 31, 2023			
	Total	Level 1	Level 2	Level 3
United States Government and Government Agency obligations	\$ 5,265,516	\$ 3,002,533	\$ 2,262,983	\$ -
Corporate obligations	2,109,945	-	2,109,945	-
Common stock	3,616,496	3,616,496	-	-
Mutual funds and exchange traded funds	15,452,772	15,452,772	-	-
Short-term investments	2,718,947	2,718,947	-	-
Certificate of deposit	3,026,535	3,026,535	-	-
	<u>\$ 32,190,211</u>	<u>\$ 27,817,283</u>	<u>\$ 4,372,928</u>	<u>\$ -</u>

NOTE 7. PROPERTY AND EQUIPMENT

The following is a summary of property and equipment as of July 31, 2024 and 2023:

	2024	2023
Shared by the Health Fund, the Retirement Fund and the Local:		
Office equipment	\$ 58,855	\$ 58,855
Furniture and fixtures	347,654	315,171
Computer equipment	496,173	490,669
Leasehold improvements	<u>785,689</u>	<u>785,689</u>
	1,688,371	1,650,384
Accumulated depreciation	<u>(1,640,771)</u>	<u>(1,630,507)</u>
Property and equipment - net	<u>\$ 47,600</u>	<u>\$ 19,877</u>

NOTE 7. PROPERTY AND EQUIPMENT (continued)

Shared by the Health Fund and the Local:

Office equipment	\$ 5,756	\$ 2,878
Accumulated depreciation	<u>(5,756)</u>	<u>(2,878)</u>
Property and equipment - net	<u>\$ -</u>	<u>\$ -</u>

Owned solely by the Health Fund:

Office equipment	\$ 8,824	\$ 8,824
Accumulated depreciation	<u>(5,911)</u>	<u>(4,299)</u>
Property and equipment - net	<u>\$ 2,913</u>	<u>\$ 4,525</u>

NOTE 8. CASH CONCENTRATIONS

The Plan places its cash with financial institutions deemed to be creditworthy. Cash balances may at times exceed the insured deposit limits.

NOTE 9. RELATED PARTY TRANSACTIONS

The Plan has common officers and Trustees with the Local 1964 I.L.A. (Local), Local 1964 I.L.A. Retirement Fund (Retirement Fund) and Local 1964 I.L.A. Staff Pension Plan (Staff Plan). The Plan shares office space and certain office expenses with the Local and the Retirement Fund. Any such amounts are reconciled on an ongoing basis. The allocation of expenses is periodically reviewed and approved by the Plan's Board of Trustees. The Plan contributes amounts on behalf of its employees for retirement benefits to the Staff Plan. As of July 31, 2024 and 2023, the following amounts were due to or from the Plan:

	<u>2024</u>	<u>2023</u>
Due (to) from Plan:		
Local	\$ 11,916	\$ (41,422)
Retirement Fund	4,633	(34,357)
Staff Plan	<u>(6,829)</u>	<u>(8,231)</u>
	<u>\$ 9,720</u>	<u>\$ (84,010)</u>

The Plan shares personnel and other office expenses with the Local and the Retirement Fund. During the years ended July 31, 2024 and 2023, the Plan allocated \$521,983 and \$506,461, respectively, to the Local for its portion of payroll, employee benefits, and related taxes and \$3,330 and \$2,647, respectively, to the Local for its portion of office expenses. During the years ended July 31, 2024 and 2023, the Plan allocated \$387,765 and \$370,770, respectively, to the Retirement Fund for its portion of payroll, employee benefits and related taxes and \$1,512 and \$1,200, respectively, to the Retirement Fund for its portion of office expenses.

NOTE 9. RELATED PARTY TRANSACTIONS (continued)

The Plan sub-leases office space and equipment to the Local and the Retirement Fund under terms of yearly operating leases. The space is allocated among the Plan and related entities using an allocation that is periodically reviewed and approved by the Plan's Board of Trustees. The Plan received office rent from these entities in the amount of \$35,351 for the years ended July 31, 2024 and 2023, respectively.

The Plan has a sub-lease agreement with the United Marine Division Local 350 which is renewed on an annual basis. During each of the years ended July 31, 2024 and 2023, the Plan collected \$1,800 and \$1,350 through this sub-lease, respectively.

The transactions above qualify as party-in-interest transactions which are exempt from the prohibited transaction rules of ERISA.

NOTE 10. BENEFIT PLANS

All employee groups of the Plan are covered by a single-employer defined contribution pension plan (Local 1964 I.L.A. Staff Plan and Trust) and a multiemployer defined benefit health plan (Management - I.L.A. Managed Care Trust Fund). Contributions are generally at fixed rates or a percentage of salary. Contributions for the years ended July 31, 2024 and 2023 were as follows:

<u>Plan</u>	<u>2024</u>	<u>2023</u>
Defined contribution plan	\$ 81,420	\$ 84,934
Health and welfare benefits	<u>197,761</u>	<u>193,212</u>
Total	<u>\$ 279,181</u>	<u>\$ 278,146</u>

All of the Plan's full time employees who have completed one year of service are covered by a defined contribution pension plan, the Local 1964 I.L.A. Staff Pension Plan. The Plan contributes 10% of an eligible employee's annual salary. The vesting periods are as follows:

First year	20%
Second year	40%
Third year	60%
Fourth year	80%
Fifth year	100%

NOTE 11. COMMITMENTS

In April 2016, the Plan extended an operating lease of a building through April 2026. The lease also includes provisions for real estate taxes included with the base rent. Rent expense totaled \$81,727 for the years ended July 31, 2024 and 2023, respectively. Real estate tax expenses totaled \$26,712 for each of the years ended July 31, 2024 and 2023.

NOTE 11. COMMITMENTS (continued)

The Plan subleases office space to the Local and Retirement Fund as well to the United Marine Division Local 350 under terms of yearly operating leases as described in Note 9.

NOTE 12. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits as reported on the financial statements to the Form 5500:

	<u>2024</u>	<u>2023</u>
Net assets available for benefits as reported on the financial statements	\$ 35,275,168	\$ 32,724,494
Estimated claims payable, claims incurred but not reported and insurance premiums payable	<u>(481,801)</u>	<u>(538,981)</u>
Net assets available for benefits as reported on Form 5500	<u>\$ 34,793,367</u>	<u>\$ 32,185,513</u>

The following is a reconciliation of cost of benefits per the financial statements to the Form 5500 for the year ending July 31, 2024:

	<u>2024</u>
Cost of benefits per the financial statements	\$ 4,536,260
Add - amounts payable at end of year	481,801
Less - amounts payable at beginning of year	<u>(538,981)</u>
Cost of benefits per the Form 5500	<u>\$ 4,479,080</u>

NOTE 13. FEES MANDATED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Plan is subject to certain fees mandated by the Patient Protection and Affordable Care Act. Fees payable to the Patient-Centered Outcomes Research Institute (PCORI) are equal to \$3.00 and \$2.79 per covered life for the 2024 and 2023 plan years, respectively. For the years ended July 31, 2024 and 2023, the Plan paid \$5,319 and \$5,677 in PCORI fees, respectively.

NOTE 14. RISKS AND UNCERTAINTIES

The Plan invests in various investments. Investments are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investments, it is at least reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits.

NOTE 15. SUBSEQUENT EVENTS

The Board of Trustees and management have evaluated subsequent events through May 7, 2025, the date the financial statements were available to be issued, and they have been evaluated in accordance with relevant accounting standards.

SUPPLEMENTAL INFORMATION

**LOCAL 1964 I.L.A.
HEALTH AND INSURANCE FUND**

SCHEDULES OF ADMINISTRATIVE EXPENSES

YEARS ENDED JULY 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
Salaries	\$ 853,835	\$ 867,408
Employee benefits	279,181	278,146
Computer and cybersecurity expenses	257,169	250,369
Occupancy costs	112,169	110,402
Payroll taxes	64,402	63,696
Accounting and auditing fees	49,591	55,892
Office expenses	43,787	16,873
Medical consultant	41,600	41,600
Legal fees	37,238	36,000
Insurance	20,514	25,366
Consulting fees	12,700	11,000
Depreciation	11,876	9,798
Postage	10,875	8,700
Telephone	9,283	8,586
	<u>9,283</u>	<u>8,586</u>
Total	<u>\$ 1,804,220</u>	<u>\$ 1,783,836</u>

**LOCAL 1964 I.L.A.
HEALTH AND INSURANCE FUND**

SCHEDULE OF ASSETS HELD AT END OF YEAR

JULY 31, 2024

Form 5500, Schedule H, Line 4i

E.I.N. 23-7248562

Plan No. 501

(a)	(b)	(c)			(d)	(e)	
		Description of Investment Including Maturity					
		Date, Rate of Interest, Collateral, Par or Maturity Value					
Identity of Issue, Borrower, Lessor or Similar Party	Type	Maturity Date	Rate of Interest	Par / Maturity Value or Shares	Cost	Current Value	
<u>1c(1) Interest-bearing cash:</u>							
	Chase Interest Bearing Accounts	IBA	Demand	Var. %	1,269,179	\$ 1,269,179	\$ 1,269,179
*	Fidelity Cash Management Funds Treasury	MMA	Demand	Var.	268,872	268,872	268,872
*	Fidelity Investment Money Market Treasury	MMA	Demand	Var.	582,980	582,980	582,980
	Total Interest-bearing cash					<u>2,121,031</u>	<u>2,121,031</u>
<u>1c(2) United States Government and Government Agency obligations:</u>							
	Federal Home Loan Mortgage Association	Note	11/15/30	6.625	58,000	78,745	66,050
	Federal Home Loan Mortgage Association	Pool	09/01/37	3.500	20	19	19
	Federal Home Loan Mortgage Association	Pool	11/01/40	4.000	1,153	1,140	1,115
	Federal Home Loan Mortgage Association	Pool	12/01/40	4.000	1,912	1,897	1,849
	Federal Home Loan Mortgage Association	Pool	02/01/44	3.500	1,905	1,919	1,785
	Federal Home Loan Mortgage Association	Pool	07/01/44	4.500	9,070	9,862	8,960
	Federal Home Loan Mortgage Association	Pool	08/01/44	3.500	2,316	2,383	2,164
	Federal Home Loan Mortgage Association	Pool	02/01/45	4.000	7,176	7,784	6,963
	Federal Home Loan Mortgage Association	Pool	12/01/45	3.000	12,854	13,246	11,545
	Federal Home Loan Mortgage Association	Pool	12/01/45	3.500	14,929	15,572	13,870
	Federal Home Loan Mortgage Association	Pool	02/01/46	4.000	5,718	6,096	5,425
	Federal Home Loan Mortgage Association	Pool	03/01/46	3.000	8,035	8,294	7,214
	Federal Home Loan Mortgage Association	Pool	06/01/46	3.500	11,275	11,746	10,464
	Federal Home Loan Mortgage Association	Pool	09/01/46	3.000	28,392	27,509	25,458
	Federal Home Loan Mortgage Association	Pool	09/01/46	3.500	22,312	23,705	20,754
	Federal Home Loan Mortgage Association	Pool	01/01/47	3.000	5,793	5,702	5,188
	Federal Home Loan Mortgage Association	Pool	07/01/47	4.000	10,144	11,131	9,731
	Federal Home Loan Mortgage Association	Pool	10/01/48	4.000	12,546	12,574	12,012
	Federal Home Loan Mortgage Association	Pool	08/01/49	4.000	21,557	22,375	20,575
	Federal Home Loan Mortgage Association	Pool	02/01/50	2.500	32,181	32,169	27,439
	Federal Home Loan Mortgage Association	Pool	02/01/50	3.000	23,994	24,474	21,329
	Federal Home Loan Mortgage Association	Pool	09/01/50	2.000	46,813	48,228	38,068
	Federal Home Loan Mortgage Association	Pool	11/01/51	2.500	99,514	101,792	84,206
	Federal Home Loan Mortgage Association	Pool	01/01/52	2.000	103,955	85,568	83,727
	Federal Home Loan Mortgage Association	Pool	02/01/52	2.500	83,771	83,247	70,860
	Federal Home Loan Mortgage Association	Pool	02/01/52	3.000	127,355	130,041	111,388
	Federal Home Loan Mortgage Association	Pool	04/01/52	2.500	94,294	77,342	79,663
	Federal Home Loan Mortgage Association	Pool	04/01/52	3.000	71,762	64,454	62,739
	Federal Home Loan Mortgage Association	Pool	05/01/52	3.500	55,046	50,471	50,010
	Federal Home Loan Mortgage Association	Pool	07/01/52	3.500	76,239	70,343	69,451
	Federal Home Loan Mortgage Association	Pool	07/01/52	5.000	76,723	75,165	75,563
	Federal Home Loan Mortgage Association	Pool	09/01/52	3.500	49,366	42,360	44,788
	Federal Home Loan Mortgage Association	Pool	10/01/52	4.500	26,788	26,140	25,815
	Federal Home Loan Mortgage Association	Pool	07/01/53	4.500	76,769	73,752	74,004
	Federal National Mortgage	Pool	06/01/33	3.000	5,879	6,029	5,568
	Federal National Mortgage	Pool	07/01/33	3.000	3,013	3,032	2,854

(a)	(b)	(c)			(d)	(e)
		Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value				
Identity of Issue, Borrower, Lessor or Similar Party	Type	Maturity Date	Rate of Interest	Par / Maturity Value or Shares	Cost	Current Value
<u>1c(2) United States Government and Government Agency obligations (continued):</u>						
Federal National Mortgage	Pool	09/01/33	3.000 %	4,143	\$ 4,274	\$ 3,923
Federal National Mortgage	Pool	09/01/36	2.000	85,118	87,764	76,786
Federal National Mortgage	Pool	01/01/37	2.000	21,405	19,375	19,215
Federal National Mortgage	Pool	02/01/41	4.000	5,009	5,303	4,837
Federal National Mortgage	Pool	05/01/41	4.500	11,525	12,631	11,428
Federal National Mortgage	Pool	08/01/41	4.500	836	897	829
Federal National Mortgage	Pool	08/01/41	4.500	1,335	1,434	1,324
Federal National Mortgage	Pool	05/01/42	3.500	11,464	10,815	10,733
Federal National Mortgage	Pool	09/01/42	4.500	1,632	1,770	1,619
Federal National Mortgage	Pool	08/01/43	3.500	7,721	7,678	7,228
Federal National Mortgage	Pool	10/01/46	3.000	32,099	33,251	28,758
Federal National Mortgage	Pool	02/01/47	3.500	26,557	27,257	24,569
Federal National Mortgage	Pool	08/01/47	4.000	1,568	1,607	1,503
Federal National Mortgage	Pool	08/01/47	4.500	1,945	2,224	1,911
Federal National Mortgage	Pool	11/01/48	4.000	5,231	5,236	4,983
Federal National Mortgage	Pool	11/01/49	3.500	16,692	17,203	15,354
Federal National Mortgage	Pool	09/01/50	2.500	37,696	39,600	32,019
Federal National Mortgage	Pool	07/01/51	2.000	224,760	226,762	181,552
Federal National Mortgage	Pool	07/01/51	2.500	226,388	234,126	192,043
Federal National Mortgage	Pool	02/01/52	2.000	84,441	66,708	68,062
Federal National Mortgage	Pool	04/01/52	2.500	220,940	188,942	186,674
Federal National Mortgage	Pool	04/01/52	3.000	26,660	23,577	23,315
Federal National Mortgage	Pool	06/01/52	4.000	113,327	108,369	106,279
Federal National Mortgage	Pool	07/01/52	3.000	61,589	52,957	53,831
Federal National Mortgage	Pool	12/01/52	5.500	103,650	104,589	104,085
Federal National Mortgage	Pool	03/01/53	5.500	26,853	24,715	26,911
United States Treasury	Note	11/30/24	1.500	138,000	136,452	136,300
United States Treasury	Bond	12/31/25	4.250	262,000	260,332	261,028
United States Treasury	Bond	01/31/26	4.250	385,000	382,770	383,753
United States Treasury	Bond	11/30/26	1.250	408,000	394,498	381,623
United States Treasury	Bond	05/31/27	2.625	532,000	517,567	511,321
United States Treasury	Note	05/15/28	2.875	102,000	102,248	97,964
United States Treasury	Bond	09/30/28	4.625	290,000	290,188	297,183
United States Treasury	Bond	11/30/28	4.375	189,000	188,321	192,130
United States Treasury	Bond	01/31/29	1.750	131,000	124,609	119,180
United States Treasury	Bond	02/28/29	4.250	262,000	262,768	265,430
United States Treasury	Bond	08/31/30	4.125	109,000	106,075	109,936
United States Treasury	Bond	06/30/31	4.250	232,000	232,526	235,988
United States Treasury	Bond	02/15/41	1.875	306,000	243,706	216,926
United States Treasury	Bond	02/15/42	2.375	102,000	86,933	76,839
United States Treasury	Bond	11/15/42	4.000	102,000	103,224	96,980
United States Treasury	Bond	05/15/46	2.500	248,000	229,819	180,246
United States Treasury	Bond	02/15/51	1.875	197,000	147,284	118,970
Total United States Government and Government Agency obligations					6,374,690	6,030,181
<u>1c(3) Corporate obligations:</u>						
Abbvie Inc	Bond	11/21/49	4.250	80,000	88,391	68,363
Amgen Inc	Bond	02/21/30	2.450	117,000	113,845	104,344
Anheuser-Busch	Note	02/01/46	4.900	66,000	67,305	62,128
Elevance Health Inc	Bond	06/15/34	5.375	109,000	110,710	111,825
Bank of America	Bond	07/22/27	1.734	146,000	141,316	137,047
CVS Health Corporation	Bond	08/21/40	2.700	102,000	89,292	69,837
Capital One Financial Corp	Bond	02/01/34	5.817	95,000	91,805	96,051

(a)	(b)	(c)			(d)	(e)
		Description of Investment Including Maturity				
		Date, Rate of Interest, Collateral, Par or Maturity Value				
Identity of Issue, Borrower, Lessor or Similar Party	Type	Maturity Date	Rate of Interest	Par / Maturity Value or Shares	Cost	Current Value
<u>1c(3) Corporate obligations (continued):</u>						
Citigroup Inc	Bond	06/03/31	2.572 %	131,000	\$ 128,258	\$ 115,084
Comcast Corp	Note	02/01/50	3.450	109,000	100,594	79,254
Enbridge Inc	Bond	11/15/53	6.700	73,000	75,560	81,558
Enterprise Products Operating LLC	Bond	02/15/43	4.450	58,000	52,290	51,159
Fiserv Inc	Bond	07/01/29	3.500	109,000	107,313	103,093
General Motors Co.	Bond	01/07/34	6.100	109,000	111,658	112,285
Home Depot Inc	Bond	04/15/30	2.700	124,000	124,200	112,599
JPMorgan Chase Bank	Note	05/01/28	3.540	80,000	78,979	77,284
JPMorgan Chase Bank	Bond	11/19/31	1.764	124,000	113,517	103,375
Kinder Morgan Inc	Note	06/01/25	4.300	80,000	80,995	79,229
Lowe's Companies, Inc.	Bond	10/15/30	1.700	109,000	101,561	91,300
Mastercard Inc	Bond	03/26/30	3.350	87,000	93,754	82,423
Morgan Stanley	Bond	01/22/47	4.375	66,000	62,414	58,213
Northrop Grumman Corp	Bond	01/15/25	2.930	87,000	86,002	86,010
Oracle Corp	Bond	04/01/30	2.950	138,000	138,771	125,344
Rogers Communications Inc	Bond	03/15/52	4.550	87,000	62,364	72,814
RTX Corp	Bond	03/15/54	6.400	95,000	98,527	106,736
T Mobile USA	Bond	07/15/33	5.050	109,000	106,090	109,164
Trust Finl Corp	Bond	06/08/34	5.867	124,000	121,535	127,958
U S Bancorp	Bond	01/23/30	5.384	87,000	87,278	88,708
UnitedHealth Group Inc	Bond	05/15/30	2.000	95,000	91,897	82,660
Verizon Communications Inc	Bond	11/20/50	2.875	102,000	91,388	65,965
Wells Fargo & Co	Bond	01/23/35	5.499	109,000	110,061	111,110
Total corporate obligations					2,927,670	2,772,920
<u>1c(4)(B) Common stocks:</u>						
ACI Worldwide Inc				254	6,672	10,980
Amicus Therapeutics Inc				1,256	17,857	12,949
Apellis Pharmaceuticals Inc				357	18,286	14,137
Argenx Se Sponsored Adr				43	10,017	22,182
Avient Corporation				193	9,004	8,731
BWX Technologies Inc				240	15,375	23,878
Braze Inc				221	11,883	9,737
Championx Corporation				396	6,134	13,567
Chewy Inc				413	11,209	9,986
Confluent Inc				212	5,359	5,304
Corebridge Finl Inc				478	11,612	14,125
Crinetics Pharmaceuticals Inc				117	4,396	6,215
Curtiss-Wright Corp				47	8,898	13,851
Deckers Outdoor Corp				16	5,189	14,762
Dolby Laboratories Inc				165	9,866	12,995
EQT Corporation				223	8,868	7,696
Emcor Group Inc				44	2,781	16,519
Entegris Inc				224	10,154	26,497
Etsy Inc				195	17,559	12,702
Expedia Inc				136	19,596	17,363
Gitlab Inc				308	14,991	15,779
GoDaddy Inc				220	16,844	31,999
Graco Inc				143	6,968	12,162
Hamilton Lane Inc				63	7,090	9,095
Hubbell Inc				40	13,401	15,826
Hubspot Inc				34	13,161	16,899
Hyatt Hotels Corp				156	9,881	22,984

(a)	(b)	(c)			(d)	(e)	
		Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value					
Identity of Issue, Borrower, Lessor or Similar Party		Type	Maturity Date	Rate of Interest	Par / Maturity Value or Shares	Cost	Current Value
<u>1c(4)(B) Common stocks (continued):</u>							
	iRhythm Technologies Inc				111	\$ 9,406	\$ 9,574
	Ideaya Biosciences Inc				366	14,990	15,756
	Immunocore Hldgs Plc Ads				233	12,724	9,250
	Inari Med Inc				155	10,087	7,217
	Insmad Inc				157	10,136	11,422
	Jfrog Ltd				463	9,936	17,853
	Knight Swift Transn Hldgs Inc				117	6,078	6,368
	Lattice Semiconductor Corp				222	12,875	11,766
	Lennox International Inc				25	13,822	14,588
	Lincoln Electric Holdings Inc				54	11,223	11,092
	Madrigal Pharmaceuticals Inc				29	6,919	8,255
	Manhattan Associates Inc				55	13,326	14,046
	Mongoddb Inc				63	19,080	15,899
	Murphy USA Inc				28	13,921	14,138
	Neurocrine Biosciences Inc				146	15,839	20,669
	New York Times Co				326	13,051	17,470
	Nordson Corp				63	8,579	15,771
	Nvent Electric Plc				174	9,633	12,638
	Option Care Health Inc				174	6,075	5,166
	Power Integrations Inc				147	7,030	10,737
	Procure Technologies Inc				193	14,374	13,709
	Raymond James Financial Inc				118	11,043	13,688
	RB Global Inc				87	5,626	6,928
	Renaissancere Holdings Ltd				64	13,879	14,842
	Royal Caribbean Cruises Ltd				84	6,764	13,165
	Sarepta Therapeutics Inc				90	11,686	12,802
	AO Smith Corp				196	10,309	16,668
	Springworks Therapeutics Inc				317	22,435	11,384
	Stifel Financial Corp				193	13,245	17,113
	Tapestry Inc				407	13,724	16,317
	Texas Roadhouse Inc				72	12,116	12,572
	Topbuild Corp				34	5,662	16,270
	Tyler Technologies Inc				51	17,658	28,974
	Wingstop Inc				65	11,171	24,302
	Wintrust Financial Corp				123	11,488	13,309
	Xenon Pharmaceuticals Inc				161	6,885	6,944
	Total common stocks					705,846	887,582
<u>1c(13) Mutual funds and exchange traded funds:</u>							
	Artisan International Value Instl				30,588	1,442,229	1,548,982
	DoubleLine Total Return Bond Fund Class I				587,033	6,122,219	5,183,506
	Loomis Sayles Investment Grade Bond Fund Class Y				138,349	1,655,470	1,372,422
	Lord Abbett Short Duration Income				601,557	2,420,009	2,328,024
	MFS International Intrinsic Value Fund Class I				25,152	931,774	1,136,612
	Vanguard Russell 1000 Growth Index ETF				35,113	1,926,222	3,236,716
	WisdomTree US Quality Dividend Growth Fund				73,797	4,999,640	5,885,311
	Total mutual funds and exchange traded funds					19,497,563	20,691,573
<u>1c(15) Certificate of deposit:</u>							
	Chase Certificate of Deposit	CD	09/11/24	4.640 %	-	2,032,073	2,037,504
	Total investments					\$ 33,658,873	\$ 34,540,791

**LOCAL 1964 I.L.A.
HEALTH AND INSURANCE FUND**

SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED JULY 31, 2024

Form 5500, Schedule H, Item 4j

E.I.N. 23-7248562
Plan No. 501

(a)	(b)	(c)	(d)	(g)	(h)	(i)
Description of Asset	Purchase Price	Selling Price	Cost of Asset	Current Value of Asset	Net Gain or (Loss)	
Fidelity Cash Management Funds Treasury	\$ 10,127,323	N/A	\$ 10,127,323	\$ 10,127,323	N/A	
Fidelity Cash Management Funds Treasury	N/A	\$ 10,222,973	10,222,973	10,222,973	\$ -	
Fidelity Investment Money Market Treasury	568,632	N/A	568,632	568,632	N/A	
Fidelity Investment Money Market Treasury	N/A	1,443,289	1,443,289	1,443,289	-	
WisdomTree US Quality Dividend Fund	3,236,070	N/A	3,236,070	3,236,070	N/A	
WisdomTree US Quality Dividend Fund	N/A	-	-	-	-	

**THE FINANCIAL STATEMENTS WILL BE PLACED IN THE
ATTACHMENT FOR THE ACCOUNTANT'S OPINION**

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF ASSETS HELD

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. 1510 - 0110 1510 - 0089 2023 This Form is Open to Public Inspection
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Part I Annual Report Identification Information	
For calendar plan year 2023 or fiscal plan year beginning <u>08/01/2023</u> and ending <u>07/31/2024</u>	
A This return/report is for:	<input checked="" type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) <input type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____ <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> 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	<input checked="" type="checkbox"/>
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here	<input type="checkbox"/>

Part II Basic Plan Information - enter all requested information	
1a Name of plan LOCAL 1964 ILA HEALTH & INSURANCE FUND	1b Three-digit plan number (PN) ▶ 501 1c Effective date of plan 12/21/1972
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) LOCAL 1964 ILA HEALTH AND INSURANCE FUND 11 TEANECK ROAD RIDGEFIELD PARK NJ 07660	2b Employer Identification Number (EIN) 23-7248562 2c Plan Sponsor's telephone number 201-440-6523 2d Business code (see instructions) 484110

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		5/15/25	BRIAN WALLACH
	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 <input checked="" type="checkbox"/> 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:	4b EIN
a Sponsor's name	4d PN
c Plan Name	

5 Total number of participants at the beginning of the plan year	5	1 078
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)	1 075
a (2) Total number of active participants at the end of the plan year	6a(2)	1 138
b Retired or separated participants receiving benefits	6b	2
c Other retired or separated participants entitled to future benefits	6c	
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	1 140
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)	
(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	25

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 4Q 4U

9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
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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) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> DCG (Individual Plan Information) - Number Attached _____ (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information - Small Plan) (3) <input checked="" type="checkbox"/> A (Insurance Information) - Number Attached <u>4</u> (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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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 _____

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF FIVE PERCENT TRANSACTIONS