

<b>Form 5500</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Annual Return/Report of Employee Benefit Plan</b>  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).  <b>▶ Complete all entries in accordance with the instructions to the Form 5500.</b>	OMB Nos. 1210-0110 1210-0089  <h1 style="text-align: center;">2024</h1>  <b>This Form is Open to Public Inspection</b>
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**Part I Annual Report Identification Information**  
 For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

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

a single-employer plan  a DFE (specify) \_\_\_\_\_

**B** This return/report is:  the first return/report  the final return/report

an amended return/report  a short plan year return/report (less than 12 months)

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

**D** Check box if filing under:  Form 5558  automatic extension  the DFVC program

special extension (enter description)

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

**Part II Basic Plan Information—enter all requested information**

<b>1a</b> Name of plan <u>INFINITY SOLAR USA</u>	<b>1b</b> Three-digit plan number (PN) ▶ <u>501</u>
<b>2a</b> 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>TML INTERNATIONAL</u> <u>INFINITY SOLAR USA</u> <u>SARA SHANKS</u> <u>808 SE CHKALOV DR STE 3 PMB 337 VANCOUVER, WA 98683-5275</u>	<b>1c</b> Effective date of plan <u>01/01/2024</u>  <b>2b</b> Employer Identification Number (EIN) <u>47-4177917</u>  <b>2c</b> Plan Sponsor's telephone number <u>360-360-2710</u>  <b>2d</b> Business code (see instructions) <u>238210</u>

**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.

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	06/02/2025	SARA SHANKS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	131
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	131
	<b>6a(2)</b>	151
	<b>6b</b>	0
	<b>6c</b>	0
	<b>6d</b>	151
	<b>6e</b>	
	<b>6f</b>	151
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	

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

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

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

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

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

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

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

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

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

**11c** Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code \_\_\_\_\_

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March 21, 2025

INFINITY SOLAR USA  
SARA SHANKS  
6405 E MILL PLAIN BLVD  
VANCOUVER WA 98661

WOODRUFF SAWYER & CO  
50 CALIFORNIA ST FL 12  
SAN FRANCISCO CA 94111-4646

Re Acct No. 1136222

Anniversary Date: January 1, 2025

We thank you for selecting Principal for your insurance needs.

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

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

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

- Contact the Employee Benefits Security Administration, an agency within the U.S. Department of Labor, at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa).
- The Department of Labor requires filings to be submitted electronically at [www.efast.dol.gov](http://www.efast.dol.gov).
- Additional help with EFAST can be obtained by calling 1-866-GO-EFAST (1-866-463-3278).

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

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

Enclosure



**Contract #** 1136222  
**Name of Plan** INFINITY SOLAR USA  
**Data Period** January 1, 2024 to December 31, 2024



**Principal Life Insurance Company  
 Schedule A (Form 5500) Worksheet**

**Section 1: Coverage**

<b>(a) Name of Insurance Carrier</b> Principal Life Insurance Company		<b>(b) EIN</b> 42-0127290	<b>(c) NAIC Code</b> 61271	
<b>(d) Contract or Id Number</b>	1136222	<b>Approx. no. of Persons cov. At End of Policy Year</b>	<b>Total (e)</b>	<b>153</b>
<b>Comblined Numbers</b>			Employees	118
			Dependents	35
<b>Policy or Contract Year</b> From <b>(f)</b> January 1, 2024 To <b>(g)</b> December 31, 2024				

**Section 2: Insurance fee and commissions information**

	<b>(a) Commissions Paid</b>	<b>(b) Fees Paid</b>
Total (from below)	2,653	0

**Section 3: Persons receiving commissions and fees**

<b>(a) Name &amp; Address of Agents or Brokers to whom Commissions or Fees Paid</b>	<b>(b) Amount of Commissions Paid</b>	<b>Fees Paid (c) Amount / (d) Purpose</b>	<b>(e) Org Code</b>
WOODRUFF SAWYER & CO 50 CALIFORNIA ST FL 12 SAN FRANCISCO CA 94111-4646	2,653		3 - Ins Agent or Broker

Reportable commissions and fees include all forms of compensation directly or indirectly attributable to your Principal Life Insurance Company policies.

**Section 8: Benefit and Contract Type**

<b>(a)</b> Health <small>(other than dental or vision)</small>	<b>(b)</b> <input checked="" type="checkbox"/> Dental	<b>(c)</b> Vision	<b>(d)</b> <input checked="" type="checkbox"/> Life Ins.
<b>(e)</b> <input checked="" type="checkbox"/> Temporary Disability <small>(accident and sickness)</small>	<b>(f)</b> Long Term Disability	<b>(g)</b> Supplemental Unemployment	<b>(h)</b> Prescription Drug
<b>(i)</b> Stop Loss <small>(large deductible)</small>	<b>(j)</b> HMO Contract	<b>(k)</b> <input checked="" type="checkbox"/> PPO Contract	<b>(l)</b> Indemnity Contract
<b>(m)</b> Other: _____			

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

**Section 10: Non-Experience Rated Contracts**

<b>(a) Total Premiums Paid to Carrier</b>	47,041
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