

<p style="text-align: center;"><b>Form 5500</b></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><b>Annual Return/Report of Employee Benefit Plan</b></p> <p style="font-size: 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>▶ <b>Complete all entries in accordance with the instructions to the Form 5500.</b></p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; font-weight: bold;">2024</p> <hr/> <p style="font-weight: bold;">This Form is Open to Public Inspection</p>
---	---	---

**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**

<p><b>1a</b> Name of plan <u>QUALITY METAL PRODUCTS, INC. FLEXIBLE BENEFITS PLAN</u></p>	<p><b>1b</b> Three-digit plan number (PN) ▶ <u>501</u></p>
<p><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>QUALITY METAL PRODUCTS, INC.</u></p> <p><u>7006 N. GALENA ROAD</u> <u>PEORIA, IL 61614-2296</u></p>	<p><b>1c</b> Effective date of plan <u>07/01/1998</u></p> <p><b>2b</b> Employer Identification Number (EIN) <u>37-0981581</u></p> <p><b>2c</b> Plan Sponsor's telephone number <u>309-692-8014</u></p> <p><b>2d</b> Business code (see instructions) <u>332700</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.

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	06/25/2025	LORI GASKINS
	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>	107
<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>	107
	<b>6a(2)</b>	112
	<b>6b</b>	0
	<b>6c</b>	0
	<b>6d</b>	112
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	

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

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

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

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

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

---

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

---

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

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

---

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

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

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

---

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
---	--	--

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

<p><b>A</b> Name of plan <b>QUALITY METAL PRODUCTS, INC. FLEXIBLE BENEFITS PLAN</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>QUALITY METAL PRODUCTS, INC.</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>37-0981581</b></p>	

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

**1 Coverage Information:**

(a) Name of insurance carrier  
**UNITEDHEALTHCARE INSURANCE COMPANY**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-2739571	79413	908903	187	09/01/2023	08/31/2024

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

<p>(a) Total amount of commissions paid <b>6809</b></p>	<p>(b) Total amount of fees paid <b>53</b></p>
---	--

**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  
**ENVISION INSURANCE GROUP LLC**      **1616 W PIONEER PKWY**  
**PEORIA, IL 61615-1945**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
6809	53	SERVICE FEE AGREEMENT	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	

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

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

**Part II Investment and Annuity Contract Information**  
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

**b** Premiums paid to carrier ..... **6b**

**c** Premiums due but unpaid at the end of the year ..... **6c**

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... **6d**  
 Specify nature of costs ▶

**e** Type of contract: (1)  individual policies (2)  group deferred annuity  
 (3)  other (specify) ▶

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

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

**a** Type of contract: (1)  deposit administration (2)  immediate participation guarantee  
 (3)  guaranteed investment (4)  other ▶

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	0
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
(6) Total additions .....	<b>7c(6)</b>	0
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	0
<b>e</b> Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
	(5) Total deductions .....	
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....	<b>7f</b>	0

**Part III Welfare Benefit Contract Information**  
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>		
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>		
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
	(4) Earned ((1) + (2) - (3)) .....		<b>9a(4)</b>	0
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>		
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>		
	(3) Incurred claims (add (1) and (2)) .....		<b>9b(3)</b>	0
	(4) Claims charged .....		<b>9b(4)</b>	
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions .....	<b>9c(1)(A)</b>		
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
	(D) Other expenses .....	<b>9c(1)(D)</b>		
	(E) Taxes .....	<b>9c(1)(E)</b>		
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>		
	(G) Other retention charges .....	<b>9c(1)(G)</b>		
	(H) Total retention .....		<b>9c(1)(H)</b>	0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		<b>9c(2)</b>	
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>	
	(2) Claim reserves .....		<b>9d(2)</b>	
	(3) Other reserves .....		<b>9d(3)</b>	
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>	

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>		74055
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....	<b>10b</b>		

Specify nature of costs.

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? .....  Yes  No

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

<p style="text-align: center;"><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: large;"><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
---	--	--

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

<p><b>A</b> Name of plan <span style="color: blue;">QUALITY METAL PRODUCTS, INC. FLEXIBLE BENEFITS PLAN</span></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><span style="color: blue;">501</span></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <span style="color: blue;">QUALITY METAL PRODUCTS, INC.</span></p>	<p><b>D</b> Employer Identification Number (EIN) <span style="color: blue;">37-0981581</span></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  
SYMETRA LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
91-0742147	68608	16-016308-000	82	09/01/2023	08/31/2024

**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><b>(a)</b> Total amount of commissions paid <span style="color: blue;">50820</span></p>	<p><b>(b)</b> Total amount of fees paid <span style="color: blue;">33761</span></p>
--	---

**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

MUTUAL MEDICAL C/O RON JONES  
416 MAIN ST STE 1025  
PEORIA, IL 61602-1126

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
50820	33761	FEES	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	

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

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

**Part II Investment and Annuity Contract Information**  
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

**b** Premiums paid to carrier ..... **6b**

**c** Premiums due but unpaid at the end of the year ..... **6c**

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... **6d**  
 Specify nature of costs ▶

**e** Type of contract: (1)  individual policies (2)  group deferred annuity  
 (3)  other (specify) ▶

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

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

- a** Type of contract: (1)  deposit administration (2)  immediate participation guarantee  
 (3)  guaranteed investment (4)  other ▶

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	0
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
(6) Total additions .....	<b>7c(6)</b>	0
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	0
<b>e</b> Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
	(5) Total deductions .....	
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....	<b>7f</b>	0

**Part III Welfare Benefit Contract Information**  
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>		
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>		
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
	(4) Earned ((1) + (2) - (3)) .....		<b>9a(4)</b>	0
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>		
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>		
	(3) Incurred claims (add (1) and (2)) .....		<b>9b(3)</b>	0
	(4) Claims charged .....		<b>9b(4)</b>	
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions .....	<b>9c(1)(A)</b>		
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
	(D) Other expenses .....	<b>9c(1)(D)</b>		
	(E) Taxes .....	<b>9c(1)(E)</b>		
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>		
	(G) Other retention charges .....	<b>9c(1)(G)</b>		
	(H) Total retention .....		<b>9c(1)(H)</b>	0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		<b>9c(2)</b>	
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>	
	(2) Claim reserves .....		<b>9d(2)</b>	
	(3) Other reserves .....		<b>9d(3)</b>	
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>	

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>		287377
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....	<b>10b</b>		

Specify nature of costs.

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? .....  Yes  No

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

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
---	--	--

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

<p><b>A</b> Name of plan <b>QUALITY METAL PRODUCTS, INC. FLEXIBLE BENEFITS PLAN</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶ <b>501</b></p>	
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>QUALITY METAL PRODUCTS, INC.</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>37-0981581</b></p>	

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

**1 Coverage Information:**

(a) Name of insurance carrier  
**AFLAC**

(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
82-2723296	60380	K5962	54	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid <b>8524</b>	(b) Total amount of fees paid <b>526</b>
---	---

**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  
**JOLI LYNN PEARSON** **13235 WALNUT STREET**  
**MANITO, IL 61546**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2836	343	FEES	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
**L. EDWARD LANTMAN** **2001 W. WILLOW KNOLLS DR STE 206**  
**PEORIA, IL 61614**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1558	47	FEES	3

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

SARAH BUSS 7800 N PIONEER CT  
PEORIA, IL 61615

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
772	43	FEES	3

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

LORI A WALLACE 2001 W WILLOW KNOLLS DR STE 206  
PEORIA, IL 61614

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
731	48	FEES	3

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

L. EDWARD LANTMAN 2001 W WILLOW KNOLLS DR STE 206  
PEORIA, IL 61614

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
644			3

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

BETTER BENEFITS GROUP LLC 2001 W WILLOW KNOLLS DR STE 205  
PEORIA, IL 61614

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
527	37	FEES	3

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

SPENCER BYRD 2315 N HAMILTON RD  
PEORIA, IL 61614

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
295			3

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

TOSHA M MCQUEARY

7322 N RADNOR RD APT 201  
PEORIA, IL 61615

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
212			3

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

MICHAEL J SKOFF

815 N CHURCH ST  
ROCKFORD, IL 61103

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
198	8	FEES	3

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

CHRIS E HATHAWAY

1201 SPRINGFIELD RD  
EAST PEORIA, IL 61611

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
105			3

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

TYE ELLIOTT

2315 W PINNACLE DR  
DUNLAP, IL 61525

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
104			3

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

MARK L RHODES

1513 W COLUMBIA TER APT 2  
PEORIA, IL 61606

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
79			3

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

NATHAN A WHITEMAN 550 PEKIN ST  
LINCOLN, IL 62656

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
48			3

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

RW GARRETT AGENCY INC 2201 WOODLAWN RD STE 00  
LINCOLN, IL 62656

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
45			3

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

ELIZABETH M GASPAROVIC 18 N SMITH ST  
PALATINE, IL 60056

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
42			3

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

ERICA KATHLEEN SKELTON 502 S DARST ST  
EUREKA, IL 61530

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
34			3

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

RYAN M BEYER 104 MEDINA CT  
EAST PEORIA, IL 61611

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
33			3

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

SCOTT A SMITH 6340 SUGARLOAF PKWY  
STE 200  
DULUTH, GA 30097

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
33			3

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

CHRISTOPHER J BAYER 11 FAIRWAY RD  
GALESBURG, IL 61401

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
32			3

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

GARY J IRVIN 675 S RIDGEVIEW LN  
PEORIA, IL 61604

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
29			3

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

MICHAEL A ORTIZ 740 CHEYENNE LN  
ELGIN, IL 60123

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
25			3

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

CHRISTOPHER A SKEETERS 716 N 12TH ST  
PETERSBURG, IL 62675

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
23			3

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

WILLIAM T GANT 117 HILLSONG LN  
BRIGHTON, TN 38011

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
22			3

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

TERRY J SILVERS 100 GREENLEAF DR  
FLAT ROCK, NC 28731

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
21			3

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

ENVISION INSURANCE GROUP LLC 1616 W PIONEER PKWY  
PEORIA, IL 61615

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
20			3

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

AMANDA HELMAN 16782 W COUNTY ROAD DD  
BIRCHWOOD, WI 54817

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
15			3

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

TODD C DEVOSS 321 N CLARK ST STE 625  
CHICAGO, IL 60654

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
10			3

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

CHRISTIE MARZARI 3348 LANELL LN  
PEARL, MS 39208

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
9			3

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

GREGORY J SHARP 702 E 5TH ST  
COAL VALLEY, IL 61240

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
8			3

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

MISTY A TUNYUCK 2001 W WILLOW KNOLLS DR STE 108  
PEORIA, IL 61614

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

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

TRAVIS J COCKBURN PO BOX 335  
JOHNSTON CITY, IL 62951

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4			3

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

KYLE J HORN 2222 W GERALD CT  
PEORIA, IL 61615

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2			3

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

MISTY A TUNYUCK

2201 BELMONT DR  
PEKIN, IL 61554

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2			3

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

GEORGE P OWENS

653 N ANTLERS DR  
MT ZION, IL 62549

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1			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	

**Part II Investment and Annuity Contract Information**  
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

**b** Premiums paid to carrier ..... **6b**

**c** Premiums due but unpaid at the end of the year ..... **6c**

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... **6d**  
 Specify nature of costs ▶

**e** Type of contract: (1)  individual policies (2)  group deferred annuity  
 (3)  other (specify) ▶

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

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

**a** Type of contract: (1)  deposit administration (2)  immediate participation guarantee  
 (3)  guaranteed investment (4)  other ▶

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	0
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
(6) Total additions .....	<b>7c(6)</b>	0
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	0
<b>e</b> Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
	(5) Total deductions .....	
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....	<b>7f</b>	0

**Part III Welfare Benefit Contract Information**  
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>		
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>		
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
	(4) Earned ((1) + (2) - (3)) .....		<b>9a(4)</b>	0
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>		
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>		
	(3) Incurred claims (add (1) and (2)) .....		<b>9b(3)</b>	0
	(4) Claims charged .....		<b>9b(4)</b>	
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions .....	<b>9c(1)(A)</b>		
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
	(D) Other expenses .....	<b>9c(1)(D)</b>		
	(E) Taxes .....	<b>9c(1)(E)</b>		
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>		
	(G) Other retention charges .....	<b>9c(1)(G)</b>		
	(H) Total retention .....		<b>9c(1)(H)</b>	0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		<b>9c(2)</b>	
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>	
	(2) Claim reserves .....		<b>9d(2)</b>	
	(3) Other reserves .....		<b>9d(3)</b>	
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>	

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>		49665
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....	<b>10b</b>		

Specify nature of costs.

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? .....  Yes  No

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

**Form 5500**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

**Annual Return/Report of Employee Benefit Plan**

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

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

OMB Nos. 1210-0110  
1210-0089

**2024**

**This Form is Open to Public Inspection**

**Part I Annual Report Identification Information**

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

- A** This return/report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- a single-employer plan  a DFE (specify) \_\_\_\_\_
- B** This return/report is:  the first return/report  the final return/report
- an amended return/report  a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here. ....▶
- D** Check box if filing under:  Form 5558  automatic extension  the DFVC program
- special extension (enter description)
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ....▶

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

<b>1a</b> Name of plan Quality Metal Products, Inc. Flexible Benefits Plan	<b>1b</b> Three-digit plan number (PN) ▶	501
	<b>1c</b> Effective date of plan	07/01/1998
<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)  Quality Metal Products, Inc.  7006 N. Galena Road  Peoria IL 61614-2296	<b>2b</b> Employer Identification Number (EIN)	37-0981581
	<b>2c</b> Plan Sponsor's telephone number	309-692-8014
	<b>2d</b> Business code (see instructions)	332700

**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>	<i>Lori A Gaskins</i>	6/25/2025	Lori Gaskins
	<b>Signature of plan administrator</b>	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	<b>Signature of employer/plan sponsor</b>	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	<b>Signature of DFE</b>	Date	Enter name of individual signing as DFE

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

Form 5500 (2024)  
v. 240311

<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>	107
<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>	107
	<b>6a(2)</b>	112
	<b>6b</b>	0
	<b>6c</b>	0
	<b>6d</b>	112
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
	<b>6g(2)</b>	
<b>h</b>	<b>6h</b>	
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	<b>7</b>	

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

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

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

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

**b General Schedules**

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

---

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

---

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

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

---

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

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

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

---