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| <p>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>Annual Return/Report of Employee Benefit Plan</p> <p>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>▶ Complete all entries in accordance with the instructions to the Form 5500.</p> | <p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2024</p> <hr/> <p>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>1a Name of plan <u>FINGER LAKES COMMUNITY HEALTH - WELFARE BENEFIT PLAN</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>FINGER LAKES COMMUNITY HEALTH CENTER</u> <u>FINGER LAKES COMMUNITY HEALTH</u></p> <p><u>PO BOX 423</u> <u>PENN YAN, NY 14527</u></p> | <p>1c Effective date of plan <u>01/01/2016</u></p> <p>2b Employer Identification Number (EIN) <u>16-1581104</u></p> <p>2c Plan Sponsor's telephone number <u>315-531-9102</u></p> <p>2d Business code (see instructions) <u>622000</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. | 07/01/2025 | JAMIE WETHERELL |
| | 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 | 192 |
| 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) | 192 |
| | 6a(2) | 199 |
| | 6b | 0 |
| | 6c | 0 |
| | 6d | 199 |
| | 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 | |

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 4Q

| | |
|---|---|
| 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 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)

| | |
|--|---|
| a Pension Schedules | b General Schedules |
| (1) <input type="checkbox"/> R (Retirement Plan Information) | (1) <input 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>5</u> |
| (4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____ | (4) <input 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 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>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>2024</p> <hr/> <p>This Form is Open to Public Inspection</p> |
|---|--|--|

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

| | | |
|--|--|------------|
| A Name of plan FINGER LAKES COMMUNITY HEALTH - WELFARE BENEFIT PLAN | B Three-digit plan number (PN) ▶ | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 FINGER LAKES COMMUNITY HEALTH CENTER | D Employer Identification Number (EIN) 16-1581104 | |

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
EXCELLUS BLUE CROSS BLUE SHIELD

| (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 |
| 15-0329043 | 55107 | 00100900 | 127 | 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 42744 | (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

BROWN & BROWN OF NEW YORK, INC **45 EAST AVENUE**
#700
ROCHESTER, NY 14604

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 42744 | | | 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. |
|----------------|--|

| | | |
|--|----------|--|
| 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 | 0 |
| 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 | 0 |
| 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 | 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:

| | | | | |
|----------|--|-----------------|---------|---------|
| a | Premiums: (1) Amount received | 9a(1) | 994799 | |
| | (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) | | 994799 |
| b | Benefit charges (1) Claims paid | 9b(1) | 1386739 | |
| | (2) Increase (decrease) in claim reserves | 9b(2) | | |
| | (3) Incurred claims (add (1) and (2)) | 9b(3) | | 1386739 |
| | (4) Claims charged | 9b(4) | | |
| c | Remainder of premium: (1) Retention charges (on an accrual basis) -- | | | |
| | (A) Commissions | 9c(1)(A) | 31535 | |
| | (B) Administrative service or other fees | 9c(1)(B) | 194517 | |
| | (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) | | 226052 |
| | (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 | 0 | |
| 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 style="text-align: center;">SCHEDULE A (Form 5500)</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>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 style="font-size: 24pt;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p> |
|---|--|---|

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

| | |
|---|---|
| <p>A Name of plan FINGER LAKES COMMUNITY HEALTH - WELFARE BENEFIT PLAN</p> | <p>B Three-digit plan number (PN) ▶ 501</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 FINGER LAKES COMMUNITY HEALTH CENTER</p> | <p>D Employer Identification Number (EIN) 16-1581104</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
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 13-5123390 | 64246 | 00520444 | 123 | 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.

| | |
|---|--|
| <p>(a) Total amount of commissions paid 4310</p> | <p>(b) Total amount of fees paid 4352</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
BROWN & BROWN OF NEW YORK INC. 500 PLUM STREET SUITE 200 SYRACUSE, NY 13204

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 4310 | 4352 | 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.

| | | |
|--|----------|--|
| 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 | 0 |
| 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 | 0 |
| 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 | |
| f Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f | 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:

| | | | |
|--|-----------------|-----------------|---|
| a Premiums: (1) Amount received | 9a(1) | | |
| (2) Increase (decrease) in amount due but unpaid | 9a(2) | | |
| (3) Increase (decrease) in unearned premium reserve | 9a(3) | | |
| (4) Earned ((1) + (2) - (3)) | | 9a(4) | 0 |
| b Benefit charges (1) Claims paid | 9b(1) | | |
| (2) Increase (decrease) in claim reserves | 9b(2) | | |
| (3) Incurred claims (add (1) and (2)) | | 9b(3) | 0 |
| (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) | 0 |
| (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 | 90657 |
| b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs. | 10b | |

Part IV Provision of Information

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

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

| | | |
|---|--|--|
| <p style="text-align: center;">SCHEDULE A (Form 5500)</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>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 style="font-size: large;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p> |
|---|--|--|

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

| | | |
|--|--|--|
| <p>A Name of plan FINGER LAKES COMMUNITY HEALTH - WELFARE BENEFIT PLAN</p> | <p>B Three-digit plan number (PN) ▶ 501</p> | |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 FINGER LAKES COMMUNITY HEALTH CENTER</p> | <p>D Employer Identification Number (EIN) 16-1581104</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
LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK

| (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 |
| 22-0832760 | 62057 | 000010258381 | 199 | 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.

| | |
|--|--|
| <p>(a) Total amount of commissions paid 1603</p> | <p>(b) Total amount of fees paid 189</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

BROWN & BROWN OF NEW YORK INC **500 PLUM ST**
STE 200
SYRACUSE, NY 13204

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 1046 | | | 3 |

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

BROWN & BROWN OF NEW YORK INC **45 EAST AVENUE**
ROCHESTER, NY 14604

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|---------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 388 | 189 | BROKER BONUS | 3 |

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

STRATEGIC NON-MEDICAL SLTNS LLC

ONE BEACON ST STE 17100
BOSTON, MA 02108

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 169 | | | 3 |

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

| | | |
|---|----------------------------|---|
| b Balance at the end of the previous year | 7b | 0 |
| 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 | 0 |
| 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 | |
| f Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f | 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) ▶ AD&D

9 Experience-rated contracts:

| | | | | |
|----------|--|-----------------|-----------------|---|
| a | Premiums: (1) Amount received | 9a(1) | | |
| | (2) Increase (decrease) in amount due but unpaid | 9a(2) | | |
| | (3) Increase (decrease) in unearned premium reserve | 9a(3) | | |
| | (4) Earned ((1) + (2) - (3)) | | 9a(4) | 0 |
| b | Benefit charges (1) Claims paid | 9b(1) | | |
| | (2) Increase (decrease) in claim reserves | 9b(2) | | |
| | (3) Incurred claims (add (1) and (2)) | | 9b(3) | 0 |
| | (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) | 0 |
| | (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 | | 12799 |
| 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 style="text-align: center;">SCHEDULE A (Form 5500)</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>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 style="font-size: large;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p> |
|---|--|--|

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

| | | |
|--|--|--|
| <p>A Name of plan FINGER LAKES COMMUNITY HEALTH - WELFARE BENEFIT PLAN</p> | <p>B Three-digit plan number (PN) ▶ 501</p> | |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 FINGER LAKES COMMUNITY HEALTH CENTER</p> | <p>D Employer Identification Number (EIN) 16-1581104</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
LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK

| (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 |
| 22-0832760 | 62057 | 000400258382 | 44 | 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 2405 | (b) Total amount of fees paid 602 |
|---|---|

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
BROWN & BROWN OF NEW YORK INC **500 PLUM ST**
STE 200
SYRACUSE, NY 13204

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 1412 | | | 3 |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
BROWN & BROWN OF NEW YORK INC **45 EAST AVENUE**
ROCHESTER, NY 14604

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|---------------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 993 | 338 | BROKER BONUS | 3 |

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

STRATEGIC NON-MEDICAL SLTNS

ONE BEACON ST
STE 17100
BOSTON, MA 02108

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | 264 | OVERRIDES | 3 |

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

| | | |
|---|----------------------------|---|
| b Balance at the end of the previous year | 7b | 0 |
| 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 | 0 |
| 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 | |
| f Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f | 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) **▶ VOLUNTARY AD&D, VOLUNTARY LIFE, VOL CHILD LIFE, VOL SPOUSE AD&D, VOL SPOUSE LIFE**

9 Experience-rated contracts:

| | | | | |
|----------|--|-----------------|-----------------|---|
| a | Premiums: (1) Amount received | 9a(1) | | |
| | (2) Increase (decrease) in amount due but unpaid | 9a(2) | | |
| | (3) Increase (decrease) in unearned premium reserve | 9a(3) | | |
| | (4) Earned ((1) + (2) - (3)) | | 9a(4) | 0 |
| b | Benefit charges (1) Claims paid | 9b(1) | | |
| | (2) Increase (decrease) in claim reserves | 9b(2) | | |
| | (3) Incurred claims (add (1) and (2)) | | 9b(3) | 0 |
| | (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) | 0 |
| | (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 | | 16032 |
| 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 style="text-align: center;">SCHEDULE A (Form 5500)</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>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 style="font-size: large;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p> |
|---|--|--|

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

| | | |
|--|--|--|
| <p>A Name of plan FINGER LAKES COMMUNITY HEALTH - WELFARE BENEFIT PLAN</p> | <p>B Three-digit plan number (PN) ▶ 501</p> | |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 FINGER LAKES COMMUNITY HEALTH CENTER</p> | <p>D Employer Identification Number (EIN) 16-1581104</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 |
| 52-0807803 | 60380 | NM565 | 26 | 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 4955 | (b) Total amount of fees paid 61 |
|---|--|

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

LAURA ANNE CALARCO **340 HORSE CREEK DR**
APT 208
NAPLES, FL 34110

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 1642 | 41 | FEES | 3 |

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

BROWN & BROWN OF NEW YORK INC **500 PLUM ST**
STE 200
SYRACUSE, NY 13204

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 1630 | | | 3 |

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

JOSEPH P CALARCO PO BOX 130
AUBURN, NY 13021

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 513 | 10 | FEES | 3 |

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

STEPHEN MARK BAUSO 16 CAYUGA ST
AUBURN, NY 13021

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 224 | | | 3 |

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

TERRY GLASBERGEN 1597 BRATTLEBORO DR
WEBSTER, NY 14580

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 207 | | | 3 |

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

KARL L FONDA 311 BROOKSBORO DR
WEBSTER, NY 14580

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 162 | | | 3 |

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

KRISTINE A ZABRISKIE 11 CHARLES ST
AUBURN, NY 13021

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 141 | | | 3 |

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

NICHOLAS CALARCO 162 YORK ST
AUBURN, NY 13021

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 49 | 10 | FEES | 3 |

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

MICHAEL J LARSON 2 OLDE PRESTWICK WAY
PENFIELD, NY 14526

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 57 | | | 3 |

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

DEBRA M PARKER 20 BOWEN ST
AUBURN, NY 13021

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 54 | | | 3 |

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

ELLEN REYNOLDS 11 JAMES ST
FAIRPORT, NY 14450

| (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

MARY L CULVER 31 GRANT AVE
PENN YAN, NY 14527

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 41 | | | 3 |

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

SHANE STICKLE 6787 VAIL DR
HAMBURG, NY 14075

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 36 | | | 3 |

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

TIMOTHY HENDERSON 13 WILD LAUREL LN
HILTON HEAD, SC 29926

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

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

DANIEL P DUPRE 4 BEDFORD WAY
PITTSFORD, NY 14534

| (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

JEFF DALABA 8500 GILLY FLOWER CT
BALDWINVILLE, NY 13027

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 19 | | | 3 |

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

BRAD JONES AND ASSOCIATES INC 19 BRITISH AMERICAN BLVD
LATHAM, NY 12110

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 18 | | | 3 |

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

BRENDAN MCCARTHY AND CREW 39 SAGINAW DR
STE 2
ROCHESTER, NY 14623

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 17 | | | 3 |

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

JOHN KUNKEL JR 170 DEVONSHIRE DR
ROCHESTER, NY 14625

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 12 | | | 3 |

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

TERESA STRONG 1070 SKATES ST
THE VILLAGES, FL 32163

| (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

LEWIS K GATHRIGHT JR 276 FAIRPORT VILLAGE LNDG
FAIRPORT, NY 14450

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 7 | | | 3 |

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

KELLY A IRVINE 15801 WHITE ORCHID LN
FORT MYERS, FL 33908

| (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

STEVEN E DALABA

7683 SEDGEWICK RIDGE RD
LEWISVILLE, NC 27023

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

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

STEVEN E DALABA

7683 SEDGEWICK RIDGE RD
LEWISVILLE, NC 27023

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

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

TED COLUCCI

299 WISCONSIN ST
ROCHESTER, NY 14609

| (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

LAURIE L SMITH

577 TRUESDALE HILL RD
LAKE GEORGE, NY 12845

| (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

| (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 | 0 |
| 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 | 0 |
| 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 | |
| f Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f | 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) ▶ **DISEASE, CRITICAL ILLNESS, VOL ACCIDENT**

9 Experience-rated contracts:

| | | | |
|--|-----------------|-----------------|---|
| a Premiums: (1) Amount received | 9a(1) | | |
| (2) Increase (decrease) in amount due but unpaid | 9a(2) | | |
| (3) Increase (decrease) in unearned premium reserve | 9a(3) | | |
| (4) Earned ((1) + (2) - (3)) | | 9a(4) | 0 |
| b Benefit charges (1) Claims paid | 9b(1) | | |
| (2) Increase (decrease) in claim reserves | 9b(2) | | |
| (3) Incurred claims (add (1) and (2)) | | 9b(3) | 0 |
| (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) | 0 |
| (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 | 33629 |
| b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs. | 10b | |

Part IV Provision of Information

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

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