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

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024

A This return/report is for:
- [ ] a multiemployer plan
- [X] 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
- [X] 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:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
INVESTORS TITLE COMPANY AND AFFILIATES GROUP BENEFITS TRUST GROUP MEDICAL INSURANCE PLAN

1b Three-digit plan number (PN) ▶ 505

1c Effective date of plan 10/01/2014

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)
INVESTORS TITLE COMPANY AND AFFILIATES

P.O. BOX 2687
CHAPEL HILL, NC 27515-2687

2b Employer Identification Number (EIN) 56-1110199

2c Plan Sponsor's telephone number 919-968-2200

2d Business code (see instructions) 551112

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.	07/17/2025	JOHN HERATH
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

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

a Sponsor's name

4b EIN

c Plan Name

4d PN

5	Total number of participants at the beginning of the plan year	**5**	629
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	627
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	574
b	Retired or separated participants receiving benefits	**6b**	6
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	580
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

4A

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] 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)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 1
- **(4)** [X] **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.) ..... [X] 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.) ..... [X] Yes [ ] No

11c Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code 119397476

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024

A Name of plan
INVESTORS TITLE COMPANY AND AFFILIATES GROUP BENEFITS TRUST GROUP MEDICAL INSURANCE PLAN

B Three-digit plan number (PN) ▶ 505

C Plan sponsor's name as shown on line 2a of Form 5500
INVESTORS TITLE COMPANY AND AFFILIATES

D Employer Identification Number (EIN)
56-1110199

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
CIGNA HEALTH AND LIFE INSURANCE COMPANY AND AFFILIATES

(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
59-1031071	67369	3335123	1020	10/01/2023	09/30/2024

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
22528	21220

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

GALLAGHER BENEFIT SERVICES INC
1550 AVIATION PARKWAY
STE 300
MORRISVILLE, NC 27560

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
22528	21220	SERVICE/GENERAL AGENT 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)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below) ▶	**7c(5)**			
	(6) Total additions			**7c(6)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below) ▶	**7e(4)**			
	(5) Total deductions			**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	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** [X] Health (other than dental or vision)
- **b** [X] Dental
- **c** [X] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [X] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [X] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	1434787		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	0		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	1434787
b Benefit charges (1) Claims paid	**9b(1)**	810916		
(2) Increase (decrease) in claim reserves	**9b(2)**	139915		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	950831
(4) Claims charged			**9b(4)**	950831
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	0		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**	0		
(D) Other expenses	**9c(1)(D)**	535642		
(E) Taxes	**9c(1)(E)**	2288		
(F) Charges for risks or other contingencies	**9c(1)(F)**	0		
(G) Other retention charges	**9c(1)(G)**	0		
(H) Total retention			**9c(1)(H)**	537930
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	0
(2) Claim reserves			**9d(2)**	1150477
(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**	1955300
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? [X] Yes [ ] No

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

CARRIER COMBINES HEALTH, DENTAL, AND VISION COVERAGE TOTALS ON SCHEDULE A.

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2023** **This Form is Open to Public Inspection.**

For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024

A Name of plan
INVESTORS TITLE COMPANY AND AFFILIATES GROUP BENEFITS TRUST GROUP MEDICAL INSURANCE PLAN

B Three-digit plan number (PN) ▶ 505

C Plan sponsor's name as shown on line 2a of Form 5500
INVESTORS TITLE COMPANY AND AFFILIATES

D Employer Identification Number (EIN)
56-1110199

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . ☐ Yes ☒ No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

CIGNA HEALTH AND LIFE INS. CO.

59-1031071

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 31 38 49 50 56 62	CLAIMS ADMIN	7278	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

(a) Enter name and EIN or address (see instructions)

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

(a) Enter name and EIN or address (see instructions)

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

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part II **Service Providers Who Fail or Refuse to Provide Information**

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

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(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024

A Name of plan
INVESTORS TITLE COMPANY AND AFFILIATES GROUP BENEFITS TRUST GROUP MEDICAL INSURANCE PLAN

B Three-digit plan number (PN) ▶ 505

C Plan sponsor's name as shown on line 2a of Form 5500
INVESTORS TITLE COMPANY AND AFFILIATES

D Employer Identification Number (EIN)
56-1110199

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	1828007	1847126
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	636547	113917
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	2464554	1961043
Liabilities			
g Benefit claims payable	1g	1179656	1150477
h Operating payables	1h	164498	138224
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through1j)	1k	1344154	1288701
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	1120400	672342

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	8016693	
(B) Participants	2a(1)(B)	1675134	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		9691827
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		0
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		9691827
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	7902523	
(2) To insurance carriers for the provision of benefits	2e(2)	1185283	
(3) Other	2e(3)	479105	
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		9566911
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	34146	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	538828	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		572974
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		10139885
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-448058
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) [X] Unmodified **(2)** [ ] Qualified **(3)** [ ] Disclaimer **(4)** [ ] Adverse

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

(1) [ ] DOL Regulation 2520.103-8 **(2)** [ ] DOL Regulation 2520.103-12(d) **(3)** [X] neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

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

(1) Name: BROWN, EDWARDS & COMPANY LLP **(2)** EIN: 54-0504608

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

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

Part IV Compliance Questions

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

During the plan year:

		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	**4a**		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	**4b**		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	**4c**		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	**4d**		X	
e Was this plan covered by a fidelity bond?	**4e**	X		2000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	**4f**		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4g**		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4h**		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	**4i**		X	
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	**4j**		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	**4k**		X	
l Has the plan failed to provide any benefit when due under the plan?	**4l**		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	**4m**		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	**4n**			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] No

If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

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

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

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

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

Investors Title
INNOVATIVE BY INSTINCT

Investors Title Company & Affiliates Group Benefits Trust Group Medical Insurance Plan

Financial Report

September 30, 2024

BROWNEDWARDS
certified public accountants

Investors Title Company & Affiliates
Group Benefits Trust Group Medical Insurance Plan

Contents

BROWNEDWARDS
certified public accountants

Independent Auditor's Report

To the Board of Directors and Management
Investors Title Company & Affiliates
Group Benefits Trust Group Medical Insurance Plan
Chapel Hill, North Carolina

Opinion

We have audited the accompanying financial statements of Investors Title Company & Affiliates Group Benefits Trust Group Medical Insurance Plan (the "Plan"), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and benefit obligations as of September 30, 2024 and 2023, and the related statement of changes in net assets available for benefits and benefit obligations for the year ended September 30, 2024, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of Investors Title Company & Affiliates Group Benefits Trust Group Medical Insurance Plan as of September 30, 2024 and 2023, and the changes in its net assets available for benefits and benefit obligations for the year ended September 30, 2024, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with generally accepted auditing standards, we:

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

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

Brown, Edwards & Company, L.L.P.

CERTIFIED PUBLIC ACCOUNTANTS

Roanoke, Virginia
July 15, 2025

Financial Statements

Investors Title Company & Affiliates
Group Benefits Trust Group Medical Insurance Plan

Statements of Net Assets Available for Benefits and Benefit Obligations

September 30, 2024 and 2023

	2024	2023
ASSETS		
Cash	$ 1,847,126	$ 1,828,007
Due from Cigna	113,917	636,547
Total assets	1,961,043	2,464,554
LIABILITIES		
Due to Cigna	138,224	164,498
NET ASSETS AVAILABLE FOR BENEFITS	1,822,819	2,300,056
BENEFIT OBLIGATIONS (Note 2)		
Claims payable and claims incurred but not reported	1,150,477	1,179,656
EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS	**$ 672,342**	**$ 1,120,400**

The Notes to Financial Statements are an integral part of these statements.

Investors Title Company & Affiliates
Group Benefits Trust Group Medical Insurance Plan
Statement of Changes in Net Assets Available for Benefits and Benefit Obligations
Year Ended September 30, 2024

NET DECREASE IN NET ASSETS AVAILABLE FOR BENEFITS	
Additions to net assets attributed to:	
Contributions	
Employer	$ 8,016,693
Participants	1,675,134
Total additions	9,691,827
Deductions from net assets attributed to:	
Health care benefits paid to participants	7,931,702
Stop loss insurance premiums	1,185,283
Retention	479,105
General and administrative expenses	34,146
Transfers out (Notes 7 and 8)	538,828
Total deductions	10,169,064
Net decrease	(477,237)
NET DECREASE IN BENEFIT OBLIGATIONS (Note 2)	
Amounts currently payable	
Claims incurred	7,873,344
Claims reported and paid	(7,902,523)
Net decrease	(29,179)
Decrease in excess of net assets available for benefits over benefit obligations	(448,058)
EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS	
Beginning of year	1,120,400
End of year	**$ 672,342**

The Notes to Financial Statements are an integral part of this statement.

Investors Title Company & Affiliates
Group Benefits Trust Group Medical Insurance Plan
Notes to Financial Statements
September 30, 2024

Note 1 – Plan Description

The following description of the Investors Title Company & Affiliates (the "Company") Group Benefits Trust Group Medical Insurance Plan (the "Plan") provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

General

The Company established the Plan and trust effective October 1, 2014. The Plan provides health insurance and prescription drug benefits for substantially all full-time employees of the Company including its subsidiaries and affiliates (collectively, the "Members"). The members are agencies affiliated with the Company who provide title and/or settlement services. Employees and their dependents are eligible to participate in the Plan upon meeting eligibility provisions. The Plan is considered fully insured by the states in which it operates. Connecticut General Life Insurance Company ("Cigna") is responsible for paying claims and administering the Health/Prescription Program. The Plan is subject to the provisions of ERISA.

Benefits

The Plan provides medical health care benefits to all eligible participants, beneficiaries, and their covered dependents. An employee becomes eligible as of the first day of the month coinciding with or next following the date of hire, providing the employee properly enrolls in the Plan. During 2024 and 2023, a PPO and HSA were offered under the terms of the Plan. An employee is defined as a (a) full-time employee working at least 30 hours per week, (b) employee on an approved leave of absence, or (c) employee on an approved disability leave.

The Plan is self-funded up to $150,000 in annual health benefits per participant. The Plan maintains aggregate stop loss insurance for the year ended September 30, 2024, totaling $7,835,112.

If the Plan is terminated, the participant is not entitled to benefits after the effective date of termination. Any such termination shall not affect a participant's right to benefits for claims incurred prior to termination.

Contributions

Benefits provided under the Plan are paid by the Company, the Members out of their general assets, and by participants' pre-tax payroll deductions. The Plan Administrator or Member will determine and periodically communicate the participant's share of the cost of the benefits provided under the Plan and may change that determination at any time.

The Company remits Member premium contributions and participants' payroll deductions to Cigna. Participant contributions are fully utilized for the cost of benefits prior to Member contributions.

Plan Administration

The Company is the Plan Administrator. Expenses of the Plan are paid by the Plan. Contributions established by the Board of Directors include an estimated amount to cover the cost of health benefits and administrative costs. Certain administrative functions are performed by employees of the Company.

Administrative Services Agreement

Cigna is the health claims administrator and network access provider and serves as the claims processor. Fees paid by the Plan to Cigna were $1,664,388 and $1,905,576 during 2024 and 2023, respectively.

Reclassifications

Certain amounts in the prior year's financial statements have been reclassified to conform to the current year's presentation.

Note 2 – Significant Accounting Policies

Basis of Accounting

The financial statements of the Plan are prepared using the accrual method of accounting.

Estimates

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires the Plan Administrator to make estimates and assumptions that affect reported amounts of assets, liabilities, benefits obligations, claims incurred but not reported (IBNR) and claims payable and changes therein, and disclosure of contingent assets and liabilities. Actual results may differ from those estimates.

Cash

The Plan maintains its cash at a commercial bank. Funds are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000. At times, deposits may exceed federally insured limits.

Due from Cigna

The Company maintains a separate deposit account with Cigna to fund and process claims. This account is funded on the 1st and 15th of each month. Cigna determines the minimum deposit amount periodically and at September 30, 2024 and 2023 the amount required was $272,000. At September 30, 2024 and 2023, the deposit account balance was $-0- and $255,239, respectively.

At September 30, 2024 and 2023, $113,917 and $636,547 were due from Cigna for amounts in excess of the Plan's aggregate stop loss and for amounts maintained in a separate deposit account.

Claims Payable and Claims Incurred but Not Reported

Plan obligations for unprocessed health claims, as well as claims incurred by active participants but not reported at that date, are estimated by the Company based on claims runout information provided by Cigna. For purposes of this calculation, the Plan does not distinguish between claims reported and not paid and obligations incurred but not reported. A provision of 25% for administrative expenses and a margin for adverse claims experience, were utilized in the calculation. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

Note 3 – Funding Policy

Plan funding is monitored by the Plan Administrator. Claim payments, stop loss insurance premiums, retention, and administrative fees and expenses are paid by the Plan's trust. Contributions to the Plan are deposited directly into the trust by the Company as stipulated by the Plan document.

Note 4 – Tax Status

The trust is maintained consistent with ERISA section 403(a) and 29 CFR 2550.403a-1. The Plan is classified as a Multiple Employer Welfare Arrangement (MEWA) by the Department of Labor (DOL).

Accounting principles generally accepted in the United States of America require the plan administrator to evaluate tax positions taken by the plan and recognize a tax liability (or asset) for any uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service (IRS). The Plan Administrator has analyzed the tax positions taken by the Plan, and has concluded that as of September 30, 2024, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements.

Note 5 – Plan Termination

Although it has expressed no intention to do so, the Company reserves the right to discontinue the Plan at any time, and for any reason, and without notice to the members.

Note 6 – Reconciliation of Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements to Schedule H of Form 5500:

	2024	2023
Net assets available for benefits per the financial statements	$ 1,822,819	$ 2,300,056
Claims payable and claims incurred but not reported	(1,150,477)	(1,179,656)
Net assets available for benefits per Schedule H of Form 5500	**$ 672,342**	**$ 1,120,400**

The following is a reconciliation of health care benefits paid to participants per the financial statements to Schedule H of Form 5500:

	2024
Health care benefits paid to participants per the financial statements	$ 7,931,702
Change in claims payable and claims incurred but not reported	(29,179)
Benefits paid per Schedule H of Form 5500	**$ 7,902,523**

Note 7 – Transfer of Plan Assets Due to Plan Split

Effective September 30, 2024, the Investors Title Company & Affiliates Group Benefits Trust (the "Trust") transferred assets totaling $538,828 to the Investors Title Company & Affiliates Group Medical Insurance Plan as part of a plan split. This action was undertaken to separate the benefits and obligations associated with a distinct group of participants, in accordance with the direction of the plan sponsor and governing plan documents. The transferred assets represent the portion of the Trust's net assets attributable to the participants who are no longer funding the Trust as of October 1, 2024. The transfer was accounted for as a reallocation of assets and did not result in a gain or loss to the Trust.

Note 8 – Subsequent Events

Subsequent events were evaluated through July 15, 2025, the date the financial statements were available to be issued.

Effective October 1, 2024, the trust's funding structure for medical benefits was modified. Employees of the ITMS managed agencies and United Title Agency Company, LLC will continue to be fully insured and funded through the trust, while medical benefits for employees of the other affiliated companies will be self-insured with funding no longer received through the trust.

Attachment to 2023 Form 5500
Form 5500 Multiple Employer Plan Participating Employer Information

Plan Sponsor's Name: INVESTORS TITLE COMPANY AND AFFILIATES
EIN: 56-1110199
Plan Name: INVESTORS TITLE COMPANY AND AFFILIATES GROUP BENEFITS TRUST GROUP MEDICAL INSURANCE PLAN
Plan Number: 505

Name of Participating Employer	EIN	Percent of Total Contributions
Atlantic Carolinas Title, LLC	83-3460768	.15
Bankers Settlement Services of SW PA LLC	25-1840799	.60
Bankers Settlement Services-Capital Regi	25-1849506	.76
Bankers Title Agency of Nebraska LLC	47-0842123	.45
Bankers Title of Central Kentucky LLC	61-1393458	.76
Bankers Title of East Tennessee LLC	56-2107494	.60
BCAC LLC	88-1888378	1.66
Beacon Title Agency LLC	65-1315201	.60
Cardinal Title Center LLC	41-2227403	.91
Heritage Title, LLC	82-3934956	1.06
Illinois Real Estate Title Center LLC	36-4508426	5.59
Investors Title Insurance Co	56-0997685	60.13
Kentucky Title Center LLC	13-4262031	.45
Liberty Premier Title LLC	93-3658534	.15
New York Bankers Title Agency West LLC/ Tier One Settlement Services	16-1583556	.30
North Carolina Title Center LLC	20-0478620	1.06
SearchCONNECT, LLC	82-2089645	2.27
Title Center of Greater Kentucky LLC	84-1677155	.45
Title Center of Indiana LLC	26-2087473	.60
Title Center of the South LLC	62-1794170	.60
United Members Title LLC	87-4530776	.15
United Title Agency Co LLC	45-3994702	1.06
University Title Company	74-1753734	19.64
Total (Company)		100%

Attachment to 2024 Form 5500
Form 5500 Multiple Employer Plan Participating Employer Information

Plan Sponsor's Name: INVESTORS TITLE COMPANY AND AFFILIATES
EIN: 56-1110199
Plan Name: INVESTORS TITLE COMPANY AND AFFILIATES GROUP BENEFITS TRUST GROUP MEDICAL INSURANCE PLAN
Plan Number: 505

Name of Participating Employer	EIN	Percent of Total Contributions
Atlantic Carolinas Title, LLC	83-3460768	.18
Bankers Settlement Services of SW PA LLC	25-1840799	.71
Bankers Settlement Services-Capital Regi	25-1849506	1.06
Bankers Title Agency of Nebraska LLC	47-0842123	.53
Bankers Title of Central Kentucky LLC	61-1393458	.53
Bankers Title of East Tennessee LLC	56-2107494	.71
BCAC LLC	88-1888378	1.76
Beacon Title Agency LLC	65-1315201	.53
Cardinal Title Center LLC	41-2227403	1.06
Heritage Title, LLC	82-3934956	1.23
Illinois Real Estate Title Center LLC	36-4508426	5.64
Investors Title Insurance Co	56-0997685	58.91
Kentucky Title Center LLC	13-4262031	.53
New York Bankers Title Agency West LLC/ Tier One Settlement Services	16-1583556	.35
Liberty Premier Title, LLC		.18
North Carolina Title Center LLC	20-0478620	1.06
SearchCONNECT, LLC	82-2089645	2.82
Title Center of Greater Kentucky LLC	84-1677155	.53
Title Center of Indiana LLC	26-2087473	.71
Title Center of the South LLC	62-1794170	.71
United Members Title LLC	87-4530776	.18
United Title Agency Co LLC	45-3994702	1.23
University Title Company	74-1753734	18.87
Total (Company)		100%