

<p style="text-align: center;">Form 5500</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p style="font-size: x-small;">This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</p> <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; text-align: center;">2023</p> <hr/> <p style="text-align: center;">This Form is Open to Public Inspection</p>
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Part I Annual Report Identification Information
 For calendar plan year 2023 or fiscal plan year beginning 11/01/2023 and ending 10/31/2024

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>ISS EMPLOYEE BENEFITS PLAN</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>504</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>INDEPENDENT SUPPORT SERVICES, INC.</u></p> <p><u>20 CRYSTAL STREET</u> <u>P.O. BOX 1320</u> <u>MONTICELLO, NY 12701</u></p>	<p>1c Effective date of plan <u>11/01/2019</u></p> <p>2b Employer Identification Number (EIN) <u>05-0535944</u></p> <p>2c Plan Sponsor's telephone number <u>845-794-5218</u></p> <p>2d Business code (see instructions) <u>624100</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.	07/22/2025	LAURIE CIRILLO
	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	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">5</td> <td style="text-align: right;">410</td> </tr> </table>	5	410																		
5	410																				
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	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"></td> <td style="text-align: right;">408</td> </tr> <tr> <td style="width:10%;"></td> <td style="text-align: right;">441</td> </tr> <tr> <td style="width:10%;"></td> <td style="text-align: right;">0</td> </tr> <tr> <td style="width:10%;"></td> <td style="text-align: right;">0</td> </tr> <tr> <td style="width:10%;"></td> <td style="text-align: right;">441</td> </tr> <tr> <td style="width:10%;"></td> <td style="text-align: right;"></td> </tr> <tr> <td style="width:10%;"></td> <td style="text-align: right;"></td> </tr> <tr> <td style="width:10%;"></td> <td style="text-align: right;"></td> </tr> <tr> <td style="width:10%;"></td> <td style="text-align: right;"></td> </tr> <tr> <td style="width:10%;"></td> <td style="text-align: right;"></td> </tr> </table>		408		441		0		0		441										
	408																				
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	0																				
	441																				
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">7</td> <td style="text-align: right;"></td> </tr> </table>	7																			
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 4H 4Q

9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input checked="" type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input checked="" type="checkbox"/> General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

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

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

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

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

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

Receipt Confirmation Code _____

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2023</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2023 or fiscal plan year beginning **11/01/2023** and ending **10/31/2024**

<p>A Name of plan ISS EMPLOYEE BENEFITS PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>504</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 INDEPENDENT SUPPORT SERVICES, INC.</p>	<p>D Employer Identification Number (EIN) 05-0535944</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	000010172254	130	11/01/2023	10/31/2024

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 2976</p>	<p>(b) Total amount of fees paid 2844</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MJL INSURANCE AGENCY INC **1075 ROUTE 82, SUITE 6**
HOPEWELL JUNCTION, NY 12533

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2976	0 0		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
FNA INSURANCE SERVICES INC **1000 WOODBURY ROAD, STE 403**
WOODBURY, NY 11797

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	2719	OVERRIDES	3

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

HUB INTERNATIONAL MIDWEST LTD

203 N LASALLE ST FL 20
CHICAGO, IL 60601-9300

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	125	BROKER BONUS	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.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year.....	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

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

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

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

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	
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	7e(5)
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	54373
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	0

Specify nature of costs.

0

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;">2023</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2023 or fiscal plan year beginning **11/01/2023** and ending **10/31/2024**

<p>A Name of plan ISS EMPLOYEE BENEFITS PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>504</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 INDEPENDENT SUPPORT SERVICES, INC.</p>	<p>D Employer Identification Number (EIN) 05-0535944</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	000010172255	130	11/01/2023	10/31/2024

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 3887</p>	<p>(b) Total amount of fees paid 1974</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MJL INSURANCE AGENCY INC **1075 ROUTE 82, SUITE 6**
HOPEWELL JUNCTION, NY 12533

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3887	0 0		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
FNA INSURANCE SERVICES INC **1000 WOODBURY ROAD, STE 403**
WOODBURY, NY 11797

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	1887	OVERRIDES	3

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

HUB INTERNATIONAL MIDWEST LTD

203 N LASALLE ST FL 20
CHICAGO, IL 60601-9300

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	87	BROKER BONUS	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
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Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year.....	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

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

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

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

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	
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	7e(5)
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	37739
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	0

Specify nature of costs.

0

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning **11/01/2023** and ending **10/31/2024**

A Name of plan ISS EMPLOYEE BENEFITS PLAN		B Three-digit plan number (PN) ▶	504
C Plan sponsor's name as shown on line 2a of Form 5500 INDEPENDENT SUPPORT SERVICES, INC.		D Employer Identification Number (EIN) 05-0535944	

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	000010172256	129	11/01/2023	10/31/2024

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 2738	(b) Total amount of fees paid 2165
--	---

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

MJL INSURANCE AGENCY INC

**1075 ROUTE 82, SUITE 6
HOPEWELL JUNCTION, NY 12533**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2738	0 0		3

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

FNA INSURANCE SERVICES INC

**1000 WOODBURY ROAD, STE 403
WOODBURY, NY 11797**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	2070	OVERRIDES	3

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

Schedule A (Form 5500) 2023
v. 230707

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

HUB INTERNATIONAL MIDWEST LTD

203 N LASALLE ST FL 20
CHICAGO, IL 60601-9300

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	95	BROKER BONUS	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. Specify nature of costs ▶	6d	

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

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

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

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	
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	7e(5)
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		41393
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		0

Specify nature of costs.

0

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2023</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2023 or fiscal plan year beginning **11/01/2023** and ending **10/31/2024**

<p>A Name of plan ISS EMPLOYEE BENEFITS PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>504</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 INDEPENDENT SUPPORT SERVICES, INC.</p>	<p>D Employer Identification Number (EIN) 05-0535944</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
VISION SERVICE PLAN

(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
22-2777159	47029	30061534	369	11/01/2023	10/31/2024

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 2312</p>	<p>(b) Total amount of fees paid 0</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

MATT LENNON **1075 ROUTE 82 STE 6**
HOPEWELL JUNCTION, NY 12533-6175

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2312	0	COMMISSION PAID	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.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year.....	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

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

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

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

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	
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	7e(5)
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		55095
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		0

Specify nature of costs.

0

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning **11/01/2023** and ending **10/31/2024**

A Name of plan ISS EMPLOYEE BENEFITS PLAN		B Three-digit plan number (PN) ▶ 504
C Plan sponsor's name as shown on line 2a of Form 5500 INDEPENDENT SUPPORT SERVICES, INC.		D Employer Identification Number (EIN) 05-0535944

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

AETNA LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-6033492	60054	0848326	621	11/01/2023	10/31/2024

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 35973	(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

MATTHEW LENNON

**1075 ROUTE 82, SUITE 6
HOPEWELL JUNCTION, NY 12533**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
29432	0 0		3

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

FNA INSURANCE SERVICES INC

**1000 WOODBURY ROAD, STE 403
WOODBURY, NY 11797**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
6540	0 0		3

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

Schedule A (Form 5500) 2023
v. 230707

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year			7b	
c Additions: (1) Contributions deposited during the year	7c(1)			
	7c(2)			
	7c(3)			
	7c(4)			
	7c(5)			
(6) Total additions			7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))			7d	0
e Deductions:				
	7e(1)			
	7e(2)			
	7e(3)			
	7e(4)			
(5) Total deductions			7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	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		304061
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		0

Specify nature of costs.

0

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. ▶



Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

April 02, 2025

INDEPENDENT SUPPORT SERVICES
20 CRYSTAL STREET
MONTICELLO NY 12701

**Lincoln Life & Annuity Company
of New York**

Service Office:

8801 Indian Hills Drive
Omaha, NE 68114-4066
toll free (800) 423-2765
www.LFG.com

Home Office: Syracuse, NY

RE: Group Policy Number: 000010172254 00000
Schedule A Reporting For: 11/01/2023 to 11/30/2024

Dear Client:

ERISA regulations may require your employee benefit plan administrator to file an annual report (Form 5500 and Schedule A) with the Department of Labor if the plan had 100 or more participants at the beginning of the plan year. If you are not sure whether you need to file a Form 5500, you may want to contact your own attorney, tax or benefits consultant.

As an aid in your completion of Schedule A, enclosed is the required information for your group insurance plan underwritten by Lincoln Life & Annuity Company of New York. Premiums reported are based on premiums received and applied within the reporting period listed above.

Contingent compensation payments are part of our overall expenses and are spread into the pricing across all lines of business. Please be advised that the broker listed below has previously received a copy of this information.

We appreciate your business and thank you for being a valued Lincoln Financial Group customer. For your convenience, please visit us at www.lincolnfinancial.com to view forms and policy information, access online service options and much more. If you have any questions, please contact us at 800-423-2765.

Enclosure

CC: MJL INS AGENCY INC
1075 ROUTE 82 SUITE 6
HOPEWELL JUNCTION NY 12533

**LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK
SCHEDULE A REPORTING INFORMATION**

A. Name of Plan: INDEPENDENT SUPPORT SERVICES

Part I - Information Concerning Insurance Contract Coverage, Fees, and Commissions

1. Coverage:

- (a) Name of insurance carrier: Lincoln Life & Annuity Company of New York
- (b) EIN: 22-0832760
- (c) NAIC code: 62057
- (d) Contract or identification number: 000010172254 00000

Benefits & Contract Type (Part III,#8)	Number of Persons on the Last Day of the Reporting Period (e)	Reporting Period	
		From (f)	To (g)
AD&D	130	11/01/2023	11/30/2024
Life	130	11/01/2023	11/30/2024

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
\$2,975.97	\$2,843.96

3. Insurance fees and commissions paid to agents, brokers, and other persons:

Name and address to whom payments were paid (a)	Amount of sales and base commissions paid (b)	Fees and other commissions paid Amount (c)	Purpose (d)	Org. Code (e)
MJL INS AGENCY INC 1075 ROUTE 82 SUITE 6 HOPEWELL JUNCTION, NY 12533	\$2,975.97			3
Totals:	\$2,975.97	\$0.00		
FNA INSURANCE SERVICES INC 1000 WOODBURY RD STE 403 WOODBURY, NY 11797		\$2,718.64	Overrides	3
Totals:	\$0.00	\$2,718.64		
HUB INTERNATIONAL MIDWEST LTD 203 N LASALLE ST FL 20 CHICAGO, IL 60601-9300		\$125.32	Broker Bonus	3
Totals:	\$0.00	\$125.32		

Part III - Welfare Benefit Contract Information

- 8. Benefit and contract type: see Part I, section 1, column 1 above
- 10. Nonexperience-rated contracts:
 - (a) Total premiums or subscription charges paid to carrier... \$54,372.85

Lincoln Life & Annuity Company of New York
Service Office: 8801 Indian Hills Drive
Omaha, NE 68114-4066



Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

April 02, 2025

INDEPENDENT SUPPORT SERVICES
20 CRYSTAL STREET
MONTICELLO NY 12701

**Lincoln Life & Annuity Company
of New York**

Service Office:

8801 Indian Hills Drive
Omaha, NE 68114-4066
toll free (800) 423-2765
www.LFG.com

Home Office: Syracuse, NY

RE: Group Policy Number: 000010172255 00000
Schedule A Reporting For: 11/01/2023 to 11/30/2024

Dear Client:

ERISA regulations may require your employee benefit plan administrator to file an annual report (Form 5500 and Schedule A) with the Department of Labor if the plan had 100 or more participants at the beginning of the plan year. If you are not sure whether you need to file a Form 5500, you may want to contact your own attorney, tax or benefits consultant.

As an aid in your completion of Schedule A, enclosed is the required information for your group insurance plan underwritten by Lincoln Life & Annuity Company of New York. Premiums reported are based on premiums received and applied within the reporting period listed above.

Contingent compensation payments are part of our overall expenses and are spread into the pricing across all lines of business. Please be advised that the broker listed below has previously received a copy of this information.

We appreciate your business and thank you for being a valued Lincoln Financial Group customer. For your convenience, please visit us at www.lincolnfinancial.com to view forms and policy information, access online service options and much more. If you have any questions, please contact us at 800-423-2765.

Enclosure

CC: MJL INS AGENCY INC
1075 ROUTE 82 SUITE 6
HOPEWELL JUNCTION NY 12533

**LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK
SCHEDULE A REPORTING INFORMATION**

A. Name of Plan: INDEPENDENT SUPPORT SERVICES

Part I - Information Concerning Insurance Contract Coverage, Fees, and Commissions

1. Coverage:

- (a) Name of insurance carrier: Lincoln Life & Annuity Company of New York
- (b) EIN: 22-0832760
- (c) NAIC code: 62057
- (d) Contract or identification number: 000010172255 00000

Benefits & Contract Type (Part III,#8)	Number of Persons on the Last Day of the Reporting Period (e)	Reporting Period	
		From (f)	To (g)
LTD	130	11/01/2023	11/30/2024

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
\$3,886.93	\$1,974.11

3. Insurance fees and commissions paid to agents, brokers, and other persons:

Name and address to whom payments were paid (a)	Amount of sales and base commissions paid (b)	Fees and other commissions paid Amount (c)	Purpose (d)	Org. Code (e)
MJL INS AGENCY INC 1075 ROUTE 82 SUITE 6 HOPEWELL JUNCTION, NY 12533	\$3,886.93			3
Totals:	\$3,886.93	\$0.00		
FNA INSURANCE SERVICES INC 1000 WOODBURY RD STE 403 WOODBURY, NY 11797		\$1,886.92	Overrides	3
Totals:	\$0.00	\$1,886.92		
HUB INTERNATIONAL MIDWEST LTD 203 N LASALLE ST FL 20 CHICAGO, IL 60601-9300		\$87.19	Broker Bonus	3
Totals:	\$0.00	\$87.19		

Part III - Welfare Benefit Contract Information

- 8. Benefit and contract type: see Part I, section 1, column 1 above
- 10. Nonexperience-rated contracts:
 - (a) Total premiums or subscription charges paid to carrier... \$37,738.52

Lincoln Life & Annuity Company of New York
Service Office: 8801 Indian Hills Drive
Omaha, NE 68114-4066



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April 02, 2025

INDEPENDENT SUPPORT SERVICES
20 CRYSTAL STREET
MONTICELLO NY 12701

**Lincoln Life & Annuity Company
of New York**

Service Office:

8801 Indian Hills Drive
Omaha, NE 68114-4066
toll free (800) 423-2765
www.LFG.com

Home Office: Syracuse, NY

RE: Group Policy Number: 000010172256 00000
Schedule A Reporting For: 11/01/2023 to 11/30/2024

Dear Client:

ERISA regulations may require your employee benefit plan administrator to file an annual report (Form 5500 and Schedule A) with the Department of Labor if the plan had 100 or more participants at the beginning of the plan year. If you are not sure whether you need to file a Form 5500, you may want to contact your own attorney, tax or benefits consultant.

As an aid in your completion of Schedule A, enclosed is the required information for your group insurance plan underwritten by Lincoln Life & Annuity Company of New York. Premiums reported are based on premiums received and applied within the reporting period listed above.

Contingent compensation payments are part of our overall expenses and are spread into the pricing across all lines of business. Please be advised that the broker listed below has previously received a copy of this information.

We appreciate your business and thank you for being a valued Lincoln Financial Group customer. For your convenience, please visit us at www.lincolnfinancial.com to view forms and policy information, access online service options and much more. If you have any questions, please contact us at 800-423-2765.

Enclosure

CC: MJL INS AGENCY INC
1075 ROUTE 82 SUITE 6
HOPEWELL JUNCTION NY 12533

**LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK
SCHEDULE A REPORTING INFORMATION**

A. Name of Plan: INDEPENDENT SUPPORT SERVICES

Part I - Information Concerning Insurance Contract Coverage, Fees, and Commissions

1. Coverage:

- (a) Name of insurance carrier: Lincoln Life & Annuity Company of New York
- (b) EIN: 22-0832760
- (c) NAIC code: 62057
- (d) Contract or identification number: 000010172256 00000

Benefits & Contract Type (Part III,#8)	Number of Persons on the Last Day of the Reporting Period (e)	Reporting Period	
		From (f)	To (g)
Weekly Income	129	11/01/2023	11/30/2024

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
\$2,737.84	\$2,164.84

3. Insurance fees and commissions paid to agents, brokers, and other persons:

Name and address to whom payments were paid (a)	Amount of sales and base commissions paid (b)	Fees and other commissions paid Amount (c)	Purpose (d)	Org. Code (e)
MJL INS AGENCY INC 1075 ROUTE 82 SUITE 6 HOPEWELL JUNCTION, NY 12533	\$2,737.84			3
Totals:	\$2,737.84	\$0.00		
FNA INSURANCE SERVICES INC 1000 WOODBURY RD STE 403 WOODBURY, NY 11797		\$2,069.62	Overrides	3
Totals:	\$0.00	\$2,069.62		
HUB INTERNATIONAL MIDWEST LTD 203 N LASALLE ST FL 20 CHICAGO, IL 60601-9300		\$95.22	Broker Bonus	3
Totals:	\$0.00	\$95.22		

Part III - Welfare Benefit Contract Information

- 8. Benefit and contract type: see Part I, section 1, column 1 above
- 10. Nonexperience-rated contracts:
 - (a) Total premiums or subscription charges paid to carrier... \$41,392.52

Lincoln Life & Annuity Company of New York
Service Office: 8801 Indian Hills Drive
Omaha, NE 68114-4066



Schedule A Form (5500) Insurance Information

If Schedule A information is required to file a complete Form 5500 or Form 5500 C/R, information from this form must be transcribed onto IRS Schedule A (Form 5500) Insurance Information form (Cat. No. 135051) as required by federal regulation.

IF YOU HAVE QUESTIONS REGARDING THE TRANSPOSITION OF INFORMATION CONTAINED IN THIS REPORT, CONTACT YOUR INTERNAL COMPLIANCE OFFICE.

INDEPENDENT SUPPORT SERVICES
LAURIE CIRILLO
20 CRYSTAL ST
MONTICELLO NY 12701-1323

Group ID: **30061534**
Insurance Carrier: Vision Service Plan
Insurance Carrier NAIC Code: 47029
Insurance Carrier FEIN: **222777159**
Benefit Type: Vision Care
Policy or Contract Year: **11/01/2023 - 11/30/2024**

Group Legal Name and Address:

**INDEPENDENT SUPPORT SERVICES
20 CRYSTAL ST
MONTICELLO NY 12701-1323**

Approximate Number of Persons Covered at the End of Policy or Contract Year: **369**

Payments:

Total Payments Made to Carrier: **\$ 55,095.16**

Insurance Fees and Commissions Paid to Agents and Brokers:

Agent or Broker	Commissions/Fees Paid for Policy or Contract Year
Matt Lennon 1075 ROUTE 82 STE 6 HOPEWELL JUNCTION NY 12533-6175	\$2,311.97

Vision Service Plan hereby certifies that this statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate as of 04/02/2025 .



ERISA 5500 SCHEDULE A TEAM
PO BOX 818091
CLEVELAND OH 44181-8091

*000005*J1KNERE*000014*

Important Document Enclosed

January 24, 2025

INDEPENDENT SUPPORT SERVICES
ALAN KULCHINSKY
20 CRYSTAL STREET
MONTICELLO NY 12701

**Re: Annual Reporting Under Employee Retirement Income Security Act of 1974 (ERISA)
For: INDEPENDENT SUPPORT SERVICES
0848326
Policy Period: November 01, 2023 through October 31, 2024**

We have enclosed information for your policy period listed above to help you complete the Schedule A to ERISA Form 5500 Annual Report. We are providing this information in accordance with U.S. Department of Labor regulations.

Note that compliance with the ERISA requirements for completion of the Annual Report and its filing with the Internal Revenue Service is the sole responsibility of employers, plan administrators and their professional advisors. Aetna Life Insurance Co. cannot and does not assume any responsibility for such compliance, but we are pleased to provide information pertaining to your insurance program as needed to complete the Report.

Information may also be included in the enclosure(s) for your consideration in completing Schedule C of your Form 5500. This information may consist of one or more of the following: Producer Service Fees, Indirect Compensation (as it pertains to meals and entertainment) and/or Direct Billed Fees. Information pertaining to Indirect Compensation and Direct Billed Fees is provided on a calendar year basis, which may not coincide with your plan year.

If you have other benefits plans with Aetna Life Insurance Co., you may receive additional ERISA information to complete your Schedule A and Schedule C for those plans under separate cover.

If you have any additional reporting needs, please contact your Aetna Life Insurance Co. account manager, or call 1-800-818-0691 to speak with the ERISA support team.

Sincerely,

Aetna Life Insurance Co.

Enclosure



INSURANCE INFORMATION
AETNA LIFE INSURANCE COMPANY
AND AFFILIATES

The following information is intended for your use in completing Schedule A of Form 5500.

For Fiscal Plan Year beginning 11/01/2023 and ending 10/31/2024

C. Name of the Plan Sponsor: INDEPENDENT SUPPORT SERVICES

PART I Information Concerning Insurance Contract Coverage, Fees, and Commissions.

1. Coverage: Traditional Prospective

(a) Name of Insurance Carrier: Aetna Life Insurance Co.	(d) Contract Number or Identification: 0848326	(e) Approximate Number of persons covered at the end of policy or contract year: 621	Policy or contract Year	
(b) EIN: 06-6033492			(f) From: 11/01/2023	(g) To: 10/31/2024
(c) NAIC Code: See Attached Listing				

2. Insurance Fees and commissions paid to agents and brokers:

Contract or Identification	(a) Name and address of the agents or brokers to whom commissions or fees were paid.	(b) Amount of commissions paid	(c) & (d) Fees Paid	
			Amount	Purpose
0848326	FNA INSURANCE SERVICES INC 1000 WOODBURY ROAD WOODBURY, NY 11797 ++	\$6,540.49		
0848326	MATTHEW LENNON 1075 ROUTE 82 HOPEWELL JUNCTION, NY 12533	\$29,432.04		
TOTAL		\$35,972.53		

Reported fees and commissions may be attributed to multiple Aetna companies.

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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. 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.

7. Benefit and contract type (check all applicable boxes)

<input type="checkbox"/> Health (other than dental or vision)	<input checked="" type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life Insurance
<input type="checkbox"/> Temporary disability (accident and sickness)	<input type="checkbox"/> Long-term disability	<input type="checkbox"/> Supplemental unemployment	<input type="checkbox"/> Prescription drug
<input type="checkbox"/> Stop loss (large deductible)	<input type="checkbox"/> HMO contract	<input type="checkbox"/> PPO contract	<input type="checkbox"/> Indemnity contract
<input type="checkbox"/> Accidental Death & Dismemberment	<input type="checkbox"/> Short Term Disability		

8. Experience rated contracts: NA

9. Non experience rated contracts:

(a) Total premiums or subscription charges paid to carrier..... \$304,060.75

(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 2 above, report amount
 Specify nature of costs -->

This information was generated as of 12/31/2024

Date 01/16/2025 10:53 FINAL RELEASE
Regina Pendergrass
 Registrar

AETNA LIFE INSURANCE COMPANY AND AFFILIATES
 hereby certifies that the foregoing statement is complete and accurate

++Not charged directly to customer or customer experience

<u>NAIC Code</u>	<u>Service Area</u>
95094	Aetna Health Inc. (a Georgia Corporation)
95003	Aetna Health Inc. (an Arizona Corporation)
60054	Aetna Life Insurance Company
N/A	Aetna Dental of California Inc.
11183	Aetna Dental Inc (a New Jersey Corporation)
95910	Aetna Dental Inc (a Texas Corporation)



**Sun Life and Health
Insurance Company**

SC3238
One Sun Life Executive Park
96 Worcester Street
Wellesley Hills, MA 02481-5699
email: ebg_commissions@sunlife.com

855

Tel: 1-800-440-1311

July 05, 2024

INDEPENDENT SUPPORT SERVICES INC.
ATTN: BENEFIT ADMINISTRATOR
20 CRYSTAL STREET
MONTICELLO, NY 12701

Re: Schedule A (Form 5500) Insurance Information
Group Policy Number: 953165

Dear Valued Customer:

We are sending you the enclosed information to assist you in completing Schedule A/C, of IRS/DOL/PBGC Form 5500. We are providing Schedule A/C information to you because we cannot be certain whether or not you require it. Sun Life does not administer your plan and cannot provide tax and legal advice regarding your plan or policies. Please let us know in writing if you do not file a Schedule A/C of Form 5500 and you do not wish to receive this information in the future. We will not resume Schedule A/C reporting with respect to the above-referenced policy unless you otherwise notify us in writing.

The enclosed information includes all the premiums and/or fees we received, as well as all commissions paid to your broker. The commission information may include:

- Base commissions which are policy specific and are included in the policy rate(s).
- Override commissions (sometimes referred to as special payments, or program management fees) which are also policy specific and generally are included in the policy rate(s).
- Bonus commission and producer conference fees which are not policy specific. They are paid based upon the anticipated annual premiums of all your broker's or administrator's policies with us. The amount of the bonus that is paid to your broker and attributable to your policy is determined by allocating the total bonus amount for the calendar year in proportion to the anticipated annual premium associated with each policy used in the calculation of the total bonus amount. Bonus payments are a company operating expense and, thus, are not directly reflected in the policy rate(s).

During the course of the year, Sun Life sales and other personnel may engage in various activities with the insurance producers connected with your ERISA plan, such as "lunch and learn" meetings, restaurant meals, attending sporting events, and/or playing golf. Generally, these activities are intended to establish or strengthen the business relationship between the Sun Life sales personnel and the insurance producers and are not provided as a compensatory payment attributable to the plan's insurance contract or to the non-insurance services being provided to the plan. Accordingly, we are not reporting such expenses unless we have determined both that a particular expense is in fact a compensatory payment and exceeds the insubstantial value reporting threshold described in the Form 5500 instructions.

The enclosed should not be used for commission and/or premium reconciliation, it is strictly for Schedule A/C Form 5500 filing purposes. If you have any questions concerning this letter or enclosed information, please contact us via the above listed information.

Sincerely,
Broker Services

CC. MJL Insurance Agency, Inc

Enclosure

5500 Schedule A Insurance Information

Name	Policy/Account Number	Date
Independent Support Services Inc. 20 Crystal Street Monticello, NY 12701	953165	07/05/2024

Name of insurance carrier	EIN (Insurance Carrier)	NAIC code	Policy or Contract Year	
			From	To
Sun Life and Health Insurance Company (U.S.)	06-0893662	80926	05/01/2023	04/30/2024
Contract or identification number	SEE ABOVE #	Approximate number of persons covered at end of policy or contract year	418	

Insurance fees and commissions paid to agents, brokers, and other persons:	
Total Amount of commissions paid \$17,613.43	

Name and address of the agents, brokers or other persons to whom commissions or fees paid MJL Insurance Agency, Inc 1075 Route 82 Suite 6 Hopewell Junction, NY 12533	Amount of commissions paid		Organization Code 3
	Type of Benefit	Base Commission ¹	
	Stop Loss Aggregate Only	\$650.23	
	Stop Loss Specific Only	\$16,963.20	

Total Premium received 05/01/2023 to 04/30/2024	Type of Benefit	Gross Premium
	Stop Loss Aggregate Only	\$28,331.76
	Stop Loss Specific Only	\$739,108.44
	Total	\$767,440.20

Comments :
 Premiums/Fees for the time period shown above.
¹ Base Commissions paid to producer during the time period shown above.
 Any questions in regards to commissions, bonus or awards should be directed to your producer.

Pursuant to 29 CFR 2520.103-5(c), Sun Life and Health Insurance Company (U.S.) certifies that the statements above are complete and accurate.

The information reported above is for informational purposes only. It is not to be relied upon for amounts that may be due and owing with respect to the Policy.

If you have questions regarding your filing obligations, please consult with your legal and/or tax advisor.