

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

- A This return/report is for: [] a multiemployer plan [] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) [X] a single-employer plan [] a DFE (specify) ____
B This return/report is: [X] 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

1a Name of plan: ELS EDUCATIONAL SERVICES WELFARE AND BENEFITS LTD
1b Three-digit plan number (PN): 507
1c Effective date of plan: 01/01/2024
2a Plan sponsor's name (employer, if for a single-employer plan): ELS EDUCATIONAL SERVICES
2b Employer Identification Number (EIN): 52-0822348
2c Plan Sponsor's telephone number: 609-759-5952
2d Business code (see instructions): 611000

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.

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Rows include plan administrator, employer/plan sponsor, and DFE.

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

Form 5500 (2024) v. 240311

| | | |
|---|--|----|
| 3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor | 3b Administrator's EIN | |
| | 3c Administrator's telephone number | |
| 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name | 4b EIN | |
| | 4d PN | |
| 5 Total number of participants at the beginning of the plan year | 5 | 46 |
| 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested..... | 6a(1) | 46 |
| | 6a(2) | 46 |
| | 6b | 0 |
| | 6c | 0 |
| | 6d | 46 |
| | 6e | |
| | 6f | 46 |
| | 6g(1) | |
| 6g(2) | | |
| 6h | | |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | 7 | |

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

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

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

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

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

| | | |
|--|--|--|
| <p>A Name of plan ELS EDUCATIONAL SERVICES WELFARE AND BENEFITS LTD</p> | <p>B Three-digit plan number (PN) ▶ 507</p> | |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 ELS EDUCATIONAL SERVICES</p> | <p>D Employer Identification Number (EIN) 52-0822348</p> | |

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

1 Coverage Information:

(a) Name of insurance carrier
THE LINCOLN NATIONAL 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 |
| 35-0472300 | 65676 | 00001D043040 | 46 | 01/01/2024 | 12/31/2024 |

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

| | |
|---|--|
| (a) Total amount of commissions paid 5428 | (b) Total amount of fees paid 3286 |
|---|--|

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
PROFESSIONAL GROUP PLANS INC **225 WIRELESS BLVD**
SUITE 200
HAUPPAUGE, NY 11788

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 0 | 2714 | OVERRIDES | 3 |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
AFORE INSURANCE SERVICES LLC **11844 BANDERA RD # 429**
HELOTES, TX 78023

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|--------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| 5428 | 572 | 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 | |
| | | | |

(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) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶ | | |
| f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/> | | |

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

| | | |
|--|--------------|--|
| a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> 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) | |
| | 7c(6) | |
| (6) Total additions | 7c(6) | |
| d Total of balance and additions (add lines 7b and 7c(6)) | 7d | |
| e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | |
| | 7e(2) | |
| | 7e(3) | |
| | 7e(4) | |
| | 7e(5) | |
| (5) Total deductions | 7e(5) | |
| f Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | 7f | |

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) |
| 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) |
| | (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) |
| | (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 | 54289 |
| b | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. | 10b | |

Specify nature of costs.

Part IV Provision of Information

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

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



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

**The Lincoln National Life
Insurance Company**

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

June 16, 2025

ELS EDUCATIONAL SERVICES, INC.
7 ROSZEL RD FL 3
PRINCETON NJ 08540

RE: Group Policy Number: 00001D043040 00000
Schedule A Reporting For: 01/01/2024 to 12/31/2024

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 The Lincoln National Life Insurance Company. 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: AFORE INSURANCE SERVICES LLC
11844 BANDERA RD #429
HELOTES TX 78023

**THE LINCOLN NATIONAL LIFE INSURANCE COMPANY
SCHEDULE A REPORTING INFORMATION**

A. Name of Plan: ELS EDUCATIONAL SERVICES, INC.

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

1. Coverage:

- (a) Name of insurance carrier: The Lincoln National Life Insurance Company
- (b) EIN: 35-0472300
- (c) NAIC code: 65676
- (d) Contract or identification number: 00001D043040 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) |
| Dental | 46 | 01/01/2024 | 12/31/2024 |

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

| | |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
| \$5,428.98 | \$3,286.77 |

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) |
|--|---|--|--------------|------------------|
| AFORE INSURANCE SERVICES LLC 11844 BANDERA RD #429 HELOTES, TX 78023 | \$5,428.98 | \$572.28 | Broker Bonus | 3 |
| Totals: | \$5,428.98 | \$572.28 | | |
| PROFESSIONAL GROUP PLANS INC 225 WIRELESS BLVD STE 200 HAUPPAUGE, NY 11788 | | \$2,714.49 | Overrides | 3 |
| Totals: | \$0.00 | \$2,714.49 | | |

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... \$54,289.89

The Lincoln National Life Insurance Company
8801 Indian Hills Drive
Omaha, NE 68114-4066