

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

Department of the Treasury Internal Revenue Service

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).

2024

Department of Labor Employee Benefits Security Administration

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

Pension Benefit Guaranty Corporation

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... [X] a single-employer plan [] a DFE... B This return/report is: [] the first return/report [] the final return/report... C If the plan is a collectively-bargained plan... D Check box if filing under: [] Form 5558 [] automatic extension... E If this is a retroactively adopted plan...

Part II Basic Plan Information—enter all requested information

1a Name of plan: ADVANCE FINANCIAL ADMINISTRATION LLC WRAP BENEFIT PLAN
1b Three-digit plan number (PN): 501
1c Effective date of plan: 11/01/2003
2a Plan sponsor's name (employer, if for a single-employer plan): ADVANCE FINANCIAL ADMINISTRATION LLC
2b Employer Identification Number (EIN): 83-2947886
2c Plan Sponsor's telephone number: 615-341-5912
2d Business code (see instructions): 522291

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 of plan administrator, Date, Enter name of individual signing as plan administrator. Includes rows for 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 type="checkbox"/> Same as Plan Sponsor ADVANCE FINANCIAL ADMINISTRATION LLC 100 OCEANSIDE DRIVE NASHVILLE, TN 37204	3b Administrator's EIN 83-2947886 3c Administrator's telephone number 615-341-5912																				
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	5 570																				
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%;">6a(1)</td><td style="text-align: right;">570</td></tr> <tr><td>6a(2)</td><td style="text-align: right;">470</td></tr> <tr><td>6b</td><td style="text-align: right;">0</td></tr> <tr><td>6c</td><td style="text-align: right;">0</td></tr> <tr><td>6d</td><td style="text-align: right;">470</td></tr> <tr><td>6e</td><td></td></tr> <tr><td>6f</td><td></td></tr> <tr><td>6g(1)</td><td></td></tr> <tr><td>6g(2)</td><td></td></tr> <tr><td>6h</td><td></td></tr> </table>	6a(1)	570	6a(2)	470	6b	0	6c	0	6d	470	6e		6f		6g(1)		6g(2)		6h	
6a(1)	570																				
6a(2)	470																				
6b	0																				
6c	0																				
6d	470																				
6e																					
6f																					
6g(1)																					
6g(2)																					
6h																					
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7 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 4L

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)

a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____ (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>5</u> (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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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 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan ADVANCE FINANCIAL ADMINISTRATION LLC WRAP BENEFIT PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 ADVANCE FINANCIAL ADMINISTRATION LLC</p>	<p>D Employer Identification Number (EIN) 83-2947886</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
CIGNA HEALTH AND 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
59-1031071	67369	3332454	470	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid 18026</p>	<p>(b) Total amount of fees paid 5401</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
MARSH AND MCLENNAN AGENCY **2300 RENAISSANCE BLVD**
CONSHOHOCKEN, PA 19428

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
18026	5401	FEES 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
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	(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)**
 (2) Dividends and credits..... **7c(2)**
 (3) Interest credited during the year..... **7c(3)**
 (4) Transferred from separate account **7c(4)**
 (5) Other (specify below)..... **7c(5)**
 ▶

(6) Total additions **7c(6)**

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)**
 (2) Administration charge made by carrier..... **7e(2)**
 (3) Transferred to separate account **7e(3)**
 (4) Other (specify below)..... **7e(4)**
 ▶

(5) Total deductions **7e(5)**

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	443604
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

<p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: large;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan ADVANCE FINANCIAL ADMINISTRATION LLC WRAP BENEFIT PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 ADVANCE FINANCIAL ADMINISTRATION LLC</p>	<p>D Employer Identification Number (EIN) 83-2947886</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
LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-1503749	65498	OK967151	235	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid 3394</p>	<p>(b) Total amount of fees paid 531</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

JSMITH LANIER & CO A MARSH & MCLENN **161 WASHINGTON STREET**
SUITE 1200
CONSHOHOCKEN, PA 19428

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3394			3

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

THE NIA GROUP **161 WASHINGTON STREET**
SUITE 1200
CONSHOHOCKEN, PA 19428

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	272	OVERRIDES	3

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

GALLAGHER BENEFIT SERVICES

2850 GOLF ROAD
 GBS FINANCE 5TH FLOOR
 ROLLING MEADOWS, IL 60008

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	259	OVERRIDES	3

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

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

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

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

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

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

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

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

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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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)	
(2) Dividends and credits.....		
(3) Interest credited during the year.....		
(4) Transferred from separate account		
(5) Other (specify below)..... ▶		
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
(1) Disbursed from fund to pay benefits or purchase annuities during year		
(2) Administration charge made by carrier.....		
(3) Transferred to separate account		
(4) Other (specify below)..... ▶		
(5) Total deductions	7e(5)	
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) **▶ BASIC AD&D VOLUNTARY 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)
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	22630
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. ▶

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

GALLAGHER BENEFIT SERVICES INC

2850 GOLF ROAD
 GBS FINANCE 5TH FLOOR
 ROLLING MEADOWS, IL 60008

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	1141	OVERRIDES	3

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

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

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

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(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) <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) **▶ BASIC TERM LIFE VOLUNTARY TERM LIFE**

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
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	84375
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. ▶

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year		7b	
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) ▶ **VOLUNTARY LONG TERM DISABILITY**

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	70863
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. ▶

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(2) Dividends and credits.....		
(3) Interest credited during the year.....		
(4) Transferred from separate account		
(5) Other (specify below)..... ▶		
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
(1) Disbursed from fund to pay benefits or purchase annuities during year		
(2) Administration charge made by carrier.....		
(3) Transferred to separate account		
(4) Other (specify below)..... ▶		
(5) Total deductions	7e(5)	
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	64845
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. ▶

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider 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.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan ADVANCE FINANCIAL ADMINISTRATION LLC WRAP BENEFIT PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 ADVANCE FINANCIAL ADMINISTRATION LLC	D Employer Identification Number (EIN) 83-2947886	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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

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

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

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

CIGNA HEALTH AND LIFE INSURANCE CO

59-1031071

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 31 38 49 50 56 62	CLAIMS ADMIN	386435	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
CASTLIGHT HEALTH 26-1989091	FOR CALENDAR YEAR 2024, CIGNA RECEIVED INDIRECT COMPENSATION FROM THIS VENDOR OF APPROXIMATELY \$3.24 PER PARTICIPANT

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
OMADA HEALTH INC 45-2355015	FOR CALENDAR YEAR 2024, CIGNA RECEIVED INDIRECT COMPENSATION FROM THIS VENDOR OF APPROXIMATELY \$1.40 PER PARTICIPANT

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
VISION SERVICE PLAN 06-1227840	FOR CALENDAR YEAR 2024, CIGNA RECEIVED INDIRECT COMPENSATION FROM THIS VENDOR OF APPROXIMATELY \$0.67 PER PARTICIPANT

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
SAGAMORE NETWORK HOSPITAL 11595 NORTH MERIDIAN STREE SUITE 600 CARMEL, IN 46032	FOR CALENDAR YEAR 2024, CIGNA RECEIVED INDIRECT COMPENSATION FROM THESE HOSPITALS OF APPROXIMATELY \$0.06 PER PARTICIPANT	

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB 1545-0047 1210-0110 1210-0000

2024

This Form is Open to Public Inspection

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

Part I Annual Report Identification Information

Form section for Part I with fields A through E for identifying the plan and reporting period.

Part II Basic Plan Information

Form section for Part II with fields 1a through 2d for providing basic plan information.

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalty of perjury and under the penalties provided in the Internal Revenue Code, I declare that the information on this return/report is true and correct, and I am not aware of any information that would cause this return/report to be materially false or incorrect.

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Includes entries for plan administrator (Ahnaf Bashir) and DFE.

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

Form 5500 (2024) v. 240311

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

11a Has the plan been determined to be a qualified plan under Section 501(c)(3) of the Internal Revenue Code for the plan year ending 12/31/2024? Yes No
If "No," explain why on the back of this form.

11b Is the plan currently in compliance with the requirements of Section 501(c)(3) of the Internal Revenue Code for the plan year ending 12/31/2024? Yes No

11c If the plan is not currently in compliance with the requirements of Section 501(c)(3) of the Internal Revenue Code for the plan year ending 12/31/2024, describe the steps the plan is taking to become compliant by the end of the plan year. If the plan is not currently in compliance with the requirements of Section 501(c)(3) of the Internal Revenue Code for the plan year ending 12/31/2024, describe the steps the plan is taking to become compliant by the end of the plan year. If the plan is not currently in compliance with the requirements of Section 501(c)(3) of the Internal Revenue Code for the plan year ending 12/31/2024, describe the steps the plan is taking to become compliant by the end of the plan year.

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Retirement Security Administration
Employee Retirement Security Administration

Insurance Information

Form 5500-INS
File as an attachment to Form 5500.
Form 5500-INS
Form 5500-INS

OMB No. 1545-0047

2024

This Form is Open to Public Inspection

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

<p>A Name of the plan Advance Financial Administration LLC Wrap Benefit Plan</p>	<p>B EIN of the issuer 501</p>
<p>C Name of the issuer Advance Financial Administration LLC</p>	<p>D Issuer identification number 83-2947886</p>

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

1 Insurance contract information

(a) Name of the insurance company
Cigna Health and Life Insurance Company

(b) Contract number	(c) Policy number	(d) Identification number	(e) Annual premium	Policy or annuity year	
				(f) Start	(g) End
59-1031071	67369	3332454	470	01/01/2024	12/31/2024

2 Insurance contract information

(a) Total amount of commissions	(b) Total amount of fees
18,026	5,401

3 Insurance contract information

(a) Name and address of the agent, broker, or other person in the business of insurance or annuity contracts
Marsh and McLennan Agency
2300 Renaissance Blvd
Conshohocken PA 19428

(b) Total amount of commissions	Total amount of fees		(e) Total amount of fees
	(c) Total amount	(d) Description	
18,026	5,401	Fees Paid	3

(a) Name and address of the agent, broker, or other person in the business of insurance or annuity contracts

(b) Total amount of commissions	Total amount of fees		(e) Total amount of fees
	(c) Total amount	(d) Description	

(a) Address, or other identifying information of the donor

(b) Taxpayer's name and address	Name of the donee		(e) Relationship of donee to taxpayer
	(c) Name	(d) Address	

(a) Address, or other identifying information of the donor

(b) Taxpayer's name and address	Name of the donee		(e) Relationship of donee to taxpayer
	(c) Name	(d) Address	

(a) Address, or other identifying information of the donor

(b) Taxpayer's name and address	Name of the donee		(e) Relationship of donee to taxpayer
	(c) Name	(d) Address	

(a) Address, or other identifying information of the donor

(b) Taxpayer's name and address	Name of the donee		(e) Relationship of donee to taxpayer
	(c) Name	(d) Address	

(a) Address, or other identifying information of the donor

(b) Taxpayer's name and address	Name of the donee		(e) Relationship of donee to taxpayer
	(c) Name	(d) Address	

Part II	Investment and Annuity Contract Information
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4	Current annual premium for the contract for the current policy year and	4	
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5	Current annual premium for the contract for the current policy year and	5	
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6	Contract or all other funds		
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a	Contract or other funds		
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b	Contract or other funds	6b	
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c	Contract or other funds	6c	
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d	Contract or other funds	6d	
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e	Contract or other funds		
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f	Contract or other funds		
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7	Contract or other funds		
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a	Contract or other funds		
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b	Contract or other funds	7b	
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c	Contract or other funds	7c(1)	
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		7c(2)	
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		7c(3)	
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		7c(4)	
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		7c(5)	
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		7c(6)	
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d	Contract or other funds	7d	
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e	Contract or other funds	7e(1)	
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		7e(2)	
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		7e(3)	
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		7e(4)	
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		7e(5)	
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f	Contract or other funds	7e(5)	
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		7f	
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Part III	Welfare Benefit Contract Information
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8 **a** **e** **i** **m** **b** **f** **j** **c** **g** **k** **d** **h** **l**

9

a	9a(1)		
	9a(2)		
	9a(3)		
		9a(4)	
b	9b(1)		
	9b(2)		
		9b(4)	
c	9c(1)(A)		
	9c(1)(B)		
	9c(1)(C)		
	9c(1)(D)		
	9c(1)(E)		
	9c(1)(F)		
	9c(1)(G)		
		9c(2)	
d	9d(1)		
	9d(2)		
	9d(3)		
		9e	
10	a	10a	443,604
	b	10b	

Part IV	Provision of Information
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11 Did the taxpayer pay any tax on the distribution? Yes No

12 See section 11 of the Internal Revenue Code for more information.

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Retirement Security Administration
Employee Retirement Security Administration

Insurance Information

Information required to be filed under section 101 of the Internal Revenue Code of 1986, as amended, and section 101 of the Internal Revenue Code of 1954, as amended.
▶ File as an attachment to Form 5500.
 Information required to be filed under section 101 of the Internal Revenue Code of 1986, as amended, and section 101 of the Internal Revenue Code of 1954, as amended.

OMB No. 1545-0047

2024

This Form is Open to Public Inspection

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

<p>A Name of the plan Advance Financial Administration LLC Wrap Benefit Plan</p>	<p>B EIN of the issuer 501</p>
<p>C Name of the issuer Advance Financial Administration LLC</p>	<p>D Issuer identification number 83-2947886</p>

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

1 Insurance contracts

(a) Name of the insurance company
Life Insurance Company of North America

(b) Policy number	(c) Policy number	(d) Insurance contract number	(e) Annual premium	Policy or contract year	
				(f) Start	(g) End
23-1503749	65498	OK967151	235	01/01/2024	12/31/2024

2 Insurance contracts with a premium of \$100,000 or more

(a) Total number of contracts	(b) Total premium
3,394	531

3 Insurance contracts with a premium of \$100,000 or more

(a) Name of the insurance company
JSMITH LANIER & CO A MARSH & MCLENN
161 Washington Street
Suite 1200
Conshohocken PA 19428

(b) Policy number	Annual premium		(e) Number of contracts
	(c) Policy number	(d) Premium	
3,394			3

(a) Name of the insurance company
The Nia Group
161 Washington Street
Suite 1200
Conshohocken PA 19428

(b) Policy number	Annual premium		(e) Number of contracts
	(c) Policy number	(d) Premium	
0		Overrides	3

(a) Address, or other identifying information of the filer

Gallagher Benefit Services
2850 Golf Road
GBS Finance 5th Floor
Rolling Meadows

IL 60008

(b) Filer's EIN	(c) Filer's SIC		(d) Filer's NAICS	(e) Filer's NAICS
	Code			
0	259		Overrides	3

(a) Address, or other identifying information of the filer

(b) Filer's EIN	(c) Filer's SIC		(d) Filer's NAICS	(e) Filer's NAICS
	Code			

(a) Address, or other identifying information of the filer

(b) Filer's EIN	(c) Filer's SIC		(d) Filer's NAICS	(e) Filer's NAICS
	Code			

(a) Address, or other identifying information of the filer

(b) Filer's EIN	(c) Filer's SIC		(d) Filer's NAICS	(e) Filer's NAICS
	Code			

(a) Address, or other identifying information of the filer

(b) Filer's EIN	(c) Filer's SIC		(d) Filer's NAICS	(e) Filer's NAICS
	Code			

Part II	Investment and Annuity Contract Information
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4	Current annual premium for the contract as of 12/31/2024	4	
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5	Current annual premium for the contract as of 12/31/2024	5	
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6	Contract as of 12/31/2024		
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a	Contract as of 12/31/2024		
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b	Contract as of 12/31/2024	6b	
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c	Contract as of 12/31/2024	6c	
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d	Contract as of 12/31/2024	6d	
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e	Contract as of 12/31/2024		
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f	Contract as of 12/31/2024		
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7	Contract as of 12/31/2024		
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a	Contract as of 12/31/2024		
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b	Contract as of 12/31/2024	7b	
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c	Contract as of 12/31/2024	7c(1)	
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		7c(2)	
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		7c(3)	
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		7c(4)	
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		7c(5)	
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d	Contract as of 12/31/2024	7c(6)	
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e	Contract as of 12/31/2024	7d	
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f	Contract as of 12/31/2024	7e(1)	
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		7e(2)	
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		7e(3)	
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		7e(4)	
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g	Contract as of 12/31/2024	7e(5)	
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f	Contract as of 12/31/2024	7f	
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**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Retirement Security Administration
Employee Retirement Security Administration

Insurance Information

Information required to be filed under section 101 of the Internal Revenue Code of 1986, as amended, and the Regulations thereunder.
▶ File as an attachment to Form 5500.
 Information required to be filed under section 1012 of the Internal Revenue Code of 1986, as amended, and the Regulations thereunder.

OMB No. 1545-0047

2024

This Form is Open to Public Inspection

For the plan year 2024 or other year beginning 01/01/2024 and ending 12/31/2024

A Name of the plan Advance Financial Administration LLC Wrap Benefit Plan	B EIN of the issuer 501
C Name of the issuer Advance Financial Administration LLC	D Issuer identification number 83-2947886

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

1 Insurance contracts

(a) Name of the issuer
 Life Insurance Company of North America

(b) ID	(c) Code	(d) Contract number	(e) Annual premium	Policy or annuity year	
				(f) Start	(g) End
23-1503749	65498	FLX965573	59	01/01/2024	12/31/2024

2 Insurance contracts with a premium of \$100,000 or more

(a) Total premium	(b) Total commission
12,656	2,337

3 Insurance contracts with a premium of \$100,000 or more

(a) Name and address of the issuer, or other person to whom the contract is assigned

J Smith Lanier and Company
 161 Washington Street
 Suite 1200
 Conshohocken PA 19428

(b) ID	Annual premium		(e) Contract number
	(c) Total	(d) Overrides	
12,656		Overrides	3

(a) Name and address of the issuer, or other person to whom the contract is assigned

Gallagher Benefit Services Inc
 2850 Golf Road
 GBS Finance 5th Floor
 Rolling Meadows IL 60008

(b) ID	Annual premium		(e) Contract number
	(c) Total	(d) Overrides	
0	1,141	Overrides	3

(a) Addressee, or other person to whom the notice is directed

The Nia Group
161 Washington Street
Suite 1200
Conshohocken

PA 19428

(b) Document ID	Document Title		(e) Page Count
	(c) Document ID	(d) Document Title	
0	1,196	Overrides	3

(a) Addressee, or other person to whom the notice is directed

(b) Document ID	Document Title		(e) Page Count
	(c) Document ID	(d) Document Title	

(a) Addressee, or other person to whom the notice is directed

(b) Document ID	Document Title		(e) Page Count
	(c) Document ID	(d) Document Title	

(a) Addressee, or other person to whom the notice is directed

(b) Document ID	Document Title		(e) Page Count
	(c) Document ID	(d) Document Title	

(a) Addressee, or other person to whom the notice is directed

(b) Document ID	Document Title		(e) Page Count
	(c) Document ID	(d) Document Title	

Part II	Investment and Annuity Contract Information
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4	Current annual premium for the contract for the current policy year and	4	
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5	Current annual premium for the contract for the current policy year and	5	
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6	Contract or all other funds		
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a	Contract or other funds		
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b	Contract or other funds	6b	
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c	Contract or other funds	6c	
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d	Contract or other funds	6d	
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e	Contract or other funds		
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f	Contract or other funds		
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7	Contract or other funds		
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a	Contract or other funds		
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b	Contract or other funds	7b	
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c	Contract or other funds	7c(1)	
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		7c(2)	
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		7c(3)	
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		7c(4)	
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		7c(5)	
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d	Contract or other funds	7c(6)	
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e	Contract or other funds	7d	
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f	Contract or other funds	7e(1)	
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		7e(2)	
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		7e(3)	
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		7e(4)	
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f	Contract or other funds	7e(5)	
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f	Contract or other funds	7f	
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**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Retirement Security Administration
Employee Retirement Security Administration

Insurance Information

This schedule is required to be filed under section 101 of the Internal Revenue Code and is a part of Form 5500.
File as an attachment to Form 5500.
 This schedule is required to be filed if the plan is a self-insured plan or a plan that is not a self-insured plan and is not a plan that is not a self-insured plan.

OMB No. 1545-0047

2024

This Form is Open to Public Inspection

For the plan year 2024 or other plan year beginning 01/01/2024 and ending 12/31/2024

A Name of the plan Advance Financial Administration LLC Wrap Benefit Plan	B EIN of the issuer 501
C Name of the issuer Advance Financial Administration LLC	D Issuer's telephone number 83-2947886

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

1 Insurance contracts

(a) Name of the issuer
 Life Insurance Company of North America

(b) Contract number	(c) Policy number	(d) Identification number	(e) Annual premium	Policy or annuity year	
				(f) Start	(g) End
23-1503749	65498	VDT961462	188	01/01/2024	12/31/2024

2 Insurance contracts that are not included in Part 1

(a) Total number of contracts	(b) Total number of contracts
10,629	1,874

3 Insurance contracts that are not included in Part 1

(a) Name of the issuer
 J Smith Lanier and Company
 161 Washington Street
 Suite 1200
 Conshohocken PA 19428

(b) Contract number	Policy or annuity year		(e) Number of contracts
	(c) Start	(d) End	
10,629	959	Fees Paid	3

(a) Name of the issuer
 Gallagher Benefit Services Inc
 2850 Golf Road
 GBS Finance 5th Floor
 Rolling Meadows IL 60008

(b) Contract number	Policy or annuity year		(e) Number of contracts
	(c) Start	(d) End	
0	915	Overrides	3

(a) Address, or other identifying information of the donor

(b) Taxpayer's name and address	Name of the donee		(e) Relationship of donee to taxpayer
	(c) Name	(d) Address	

(a) Address, or other identifying information of the donor

(b) Taxpayer's name and address	Name of the donee		(e) Relationship of donee to taxpayer
	(c) Name	(d) Address	

(a) Address, or other identifying information of the donor

(b) Taxpayer's name and address	Name of the donee		(e) Relationship of donee to taxpayer
	(c) Name	(d) Address	

(a) Address, or other identifying information of the donor

(b) Taxpayer's name and address	Name of the donee		(e) Relationship of donee to taxpayer
	(c) Name	(d) Address	

(a) Address, or other identifying information of the donor

(b) Taxpayer's name and address	Name of the donee		(e) Relationship of donee to taxpayer
	(c) Name	(d) Address	

Part II	Investment and Annuity Contract Information
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4	Current annual premium for the contract as of 12/31/2024	4	
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5	Current annual premium for the contract as of 12/31/2024	5	
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6	Contract as of 12/31/2024		
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a	Contract as of 12/31/2024		
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b	Contract as of 12/31/2024	6b	
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c	Contract as of 12/31/2024	6c	
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d	Contract as of 12/31/2024	6d	
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e	Contract as of 12/31/2024		
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f	Contract as of 12/31/2024		
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7	Contract as of 12/31/2024		
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a	Contract as of 12/31/2024		
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b	Contract as of 12/31/2024	7b	
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c	Contract as of 12/31/2024	7c(1)	
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		7c(2)	
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		7c(3)	
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		7c(4)	
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		7c(5)	
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d	Contract as of 12/31/2024	7c(6)	
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e	Contract as of 12/31/2024	7d	
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f	Contract as of 12/31/2024		
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		7e(1)	
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		7e(2)	
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		7e(3)	
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		7e(4)	
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		7e(5)	
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f	Contract as of 12/31/2024	7e(5)	
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f	Contract as of 12/31/2024	7f	
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Part III	Welfare Benefit Contract Information
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- 8** **a** **b** **c** **d**
- e** **f** **g** **h**
- i** **j** **k** **l**
- m** **Voluntary Long Term Disability**

9	a	9a(1)		
		9a(2)		
		9a(3)		
				9a(4)
	b	9b(1)		
		9b(2)		
				9b(3)
				9b(4)
	c	9c(1)(A)		
		9c(1)(B)		
		9c(1)(C)		
		9c(1)(D)		
		9c(1)(E)		
		9c(1)(F)		
		9c(1)(G)		
				9c(1)(H)
				9c(2)
	d			9d(1)
				9d(2)
				9d(3)
	e			9e
10	a			10a 70,863
	b			10b

Part IV	Provision of Information
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- 11** Did you incur any debt or liability on your behalf during the year? Yes No
- 12** Have you filed for bankruptcy during the year? Yes No

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Retirement Security Administration
Employee Retirement Security Administration

Insurance Information

This schedule is required to be filed under section 101 of the Internal Revenue Code and is subject to the requirements of section 101 of the Code.
File as an attachment to Form 5500.
 This schedule is required to be filed with the Form 5500 for the plan year ending 12/31/2024.

OMB No. 1545-0047

2024

This Form is Open to Public Inspection

For the plan year 2024 or other year beginning 01/01/2024 and ending 12/31/2024

<p>A Name of the plan Advance Financial Administration LLC Wrap Benefit Plan</p>	<p>B EIN of the issuer 501</p>
<p>C Name of the issuer Advance Financial Administration LLC</p>	<p>D Issuer identification number 83-2947886</p>

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

1 Insurance contract information

(a) Name of the insurance company
Life Insurance Company of North America

(b) Contract number	(c) Policy number	(d) Identification number	(e) Annual premium	Policy or annuity year	
				(f) Start	(g) End
23-1503749	65498	VDT961461	200	01/01/2024	12/31/2024

2 Insurance contract fees and commissions

(a) Total fees and commissions	(b) Total fees and commissions
9,727	1,737

3 Insurance contract address

(a) Name and address of the insurance company, or other person or entity that is the issuer of the contract

J Smith Lanier and Company
161 Washington Street
Suite 1200
Conshohocken PA 19428

(b) Contract number	Policy or annuity year		(e) Number of contracts
	(c) Start	(d) End	
9,727	889	Overrides	3

(a) Name and address of the insurance company, or other person or entity that is the issuer of the contract

Gallagher Benefit Services Inc
2850 Golf Road
GBS Finance 5th Floor
Rolling Meadows IL 60008

(b) Contract number	Policy or annuity year		(e) Number of contracts
	(c) Start	(d) End	
0	848	Fees Paid	3

(a) Address, or other identifying information of the donor

(b) Name of the donor	Name of the donee		(e) Relationship of donee to donor
	(c) Name	(d) Address	

(a) Address, or other identifying information of the donor

(b) Name of the donor	Name of the donee		(e) Relationship of donee to donor
	(c) Name	(d) Address	

(a) Address, or other identifying information of the donor

(b) Name of the donor	Name of the donee		(e) Relationship of donee to donor
	(c) Name	(d) Address	

(a) Address, or other identifying information of the donor

(b) Name of the donor	Name of the donee		(e) Relationship of donee to donor
	(c) Name	(d) Address	

(a) Address, or other identifying information of the donor

(b) Name of the donor	Name of the donee		(e) Relationship of donee to donor
	(c) Name	(d) Address	

Part II	Investment and Annuity Contract Information
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4	Current annual premium for the contract for the current policy year and	4	
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5	Current annual premium for the contract for the current policy year and	5	
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6	Contract or all contract values		
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a	Contract or all contract values		
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b	Contract or all contract values	6b	
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c	Contract or all contract values	6c	
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d	Contract or all contract values	6d	
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e	Contract or all contract values		
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f	Contract or all contract values		
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7	Contract or all contract values		
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a	Contract or all contract values		
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b	Contract or all contract values	7b	
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c	Contract or all contract values	7c(1)	
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	Contract or all contract values	7c(2)	
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	Contract or all contract values	7c(3)	
--	---------------------------------	--------------	--

	Contract or all contract values	7c(4)	
--	---------------------------------	--------------	--

	Contract or all contract values	7c(5)	
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d	Contract or all contract values	7c(6)	
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e	Contract or all contract values	7d	
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f	Contract or all contract values	7e(1)	
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	Contract or all contract values	7e(2)	
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	Contract or all contract values	7e(3)	
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	Contract or all contract values	7e(4)	
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	Contract or all contract values	7e(5)	
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f	Contract or all contract values	7e(5)	
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	Contract or all contract values	7f	
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Part III	Welfare Benefit Contract Information
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- 8** **a** **b** **c** **d**
- e** **f** **g** **h**
- i** **j** **k** **l**
- m**

9

a	9a(1)		
	9a(2)		
	9a(3)		
		9a(4)	
b	9b(1)		
	9b(2)		
		9b(4)	
c	9c(1)(A)		
	9c(1)(B)		
	9c(1)(C)		
	9c(1)(D)		
	9c(1)(E)		
	9c(1)(F)		
	9c(1)(G)		
		9c(2)	
d	9d(1)		
	9d(2)		
	9d(3)		
		9e	
10	a	10a	64,845
	b	10b	

Part IV	Provision of Information
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- 11** Did the insured pay any... Yes No
- 12** ...

(b) [Redacted]

(b) [Redacted]

(b) [Redacted]

(b) [Redacted]

(b) [Redacted]

(b) [Redacted]

(b) [Redacted]

(b) [Redacted]

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. If you are a self-insured employer, you must report compensation received by any individual who is a service provider, directly or indirectly, of \$5,000 or more in total compensation for any or all services provided to the plan or your employees during the plan year.

(a) Enter the name of the provider or address where the provider is located.

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59-1031071

(b) Enter the name of the provider.	(c) Role of the provider, such as physician, administrator, or other service provider.	(d) Enter the amount of compensation received by the provider, including any other compensation.	(e) Did the provider receive compensation from the plan or from any other source?	(f) Did the provider receive compensation from the plan or from any other source, including any other compensation?	(g) Enter the amount of compensation received by the provider, including any other compensation.	(h) Did the provider receive compensation from the plan or from any other source, including any other compensation?
12 13 31 38 49 50 56 62 Claims Admin		386,435	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

(a) Enter the name of the provider or address where the provider is located.

(b) Enter the name of the provider.	(c) Role of the provider, such as physician, administrator, or other service provider.	(d) Enter the amount of compensation received by the provider, including any other compensation.	(e) Did the provider receive compensation from the plan or from any other source?	(f) Did the provider receive compensation from the plan or from any other source, including any other compensation?	(g) Enter the amount of compensation received by the provider, including any other compensation.	(h) Did the provider receive compensation from the plan or from any other source, including any other compensation?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter the name of the provider or address where the provider is located.

(b) Enter the name of the provider.	(c) Role of the provider, such as physician, administrator, or other service provider.	(d) Enter the amount of compensation received by the provider, including any other compensation.	(e) Did the provider receive compensation from the plan or from any other source?	(f) Did the provider receive compensation from the plan or from any other source, including any other compensation?	(g) Enter the amount of compensation received by the provider, including any other compensation.	(h) Did the provider receive compensation from the plan or from any other source, including any other compensation?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide the information requested, or explain why you cannot or choose not to provide the information requested or why you cannot or choose not to provide the information requested.

(a) Provide the name of the provider or the address of the provider.	(b) Provide the date of the incident.	(c) Describe the nature of the incident and the provider's response.

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(a) Provide the name of the provider or the address of the provider.	(b) Provide the date of the incident.	(c) Describe the nature of the incident and the provider's response.

Part III	Termination Information on Accountants and Enrolled Actuaries (see instructions) 0000 0000 000 00y 00r000 00 0000d0d0
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a 000 00	b 000
c 00000000	
d 0ddr0000	e 000000000

000000000

a 000 00	b 000
c 00000000	
d 0ddr0000	e 000000000

000000000

a 000 00	b 000
c 00000000	
d 0ddr0000	e 000000000

000000000

a 000 00	b 000
c 00000000	
d 0ddr0000	e 000000000

000000000

a 000 00	b 000
c 00000000	
d 0ddr0000	e 000000000

000000000