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:
- [ ] 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
ADVANCED BLENDING SOLUTIONS, LLC LIFE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan
01/01/2024

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
ADVANCED BLENDING SOLUTIONS

PO BOX 37
WALLACE, MI 49893

W5649 CO ROAD 342
WALLACE, MI 49893

2b Employer Identification Number (EIN)
26-4659655

2c Plan Sponsor's telephone number
906-914-4180

2d Business code (see instructions)
339900

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

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	07/31/2025	BETH BELCHER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor	**3b** Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:	**4b** EIN	
a Sponsor's name **c** Plan Name	**4d** PN	
5 Total number of participants at the beginning of the plan year	**5**	109
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1) Total number of active participants at the beginning of the plan year	**6a(1)**	109
a(2) Total number of active participants at the end of the plan year	**6a(2)**	108
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	0
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	108
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f Total. Add lines **6d** and **6e**.	**6f**	108
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

4B

9a Plan funding arrangement (check all that apply)
- (1) [X] Insurance
- (2) [ ] Code section 412(e)(3) insurance contracts
- (3) [ ] Trust
- (4) [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- (1) [X] Insurance
- (2) [ ] Code section 412(e)(3) insurance contracts
- (3) [ ] Trust
- (4) [ ] General assets of the sponsor

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

a Pension Schedules
- (1) [ ] **R** (Retirement Plan Information)
- (2) [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4) [ ] **DCG** (Individual Plan Information) – Number Attached ______
- (5) [ ] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules
- (1) [ ] **H** (Financial Information)
- (2) [ ] **I** (Financial Information – Small Plan)
- (3) [X] **A** (Insurance Information) – Number Attached 1
- (4) [ ] **C** (Service Provider Information)
- (5) [ ] **D** (DFE/Participating Plan Information)
- (6) [ ] **G** (Financial Transaction Schedules)

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

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) .... ☐ 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______________________

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	**Insurance Information** This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 **2024** **This Form is Open to Public Inspection**

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

A Name of plan
ADVANCED BLENDING SOLUTIONS, LLC LIFE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
ADVANCED BLENDING SOLUTIONS

D Employer Identification Number (EIN)
26-4659655

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
UNITED OF OMAHA 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
47-0322111	69868	G000B8Y2	108	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
0	203

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

R&R INSURANCE SERVICES, INC.
N14W23900 STONE RIDGE DR.
WAUKESHA, WI 53188

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b Balance at the end of the previous year			7b	
c Additions: (1) Contributions deposited during the year	7c(1)			
(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 ☐ paid in cash, or ☐ 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	3333
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. ▶

Mutual of Omaha
3300 Mutual of Omaha Plaza | Omaha, NE 68175

February 12, 2025

ADVANCED BLENDING SOLUTIONS
W5649 COUNTY ROAD 342
WALLACE, MI 49893

Re: Certified Information for Department of Labor
Form 5500, Schedule A – Group Number(s):

GLUG0B8Y2	GUC 0B8Y2	GUDE0B8Y2
GUDH0B8Y2	GUPR0B8Y2	GVTL0B8Y2

Thank you for choosing Mutual of Omaha as your group insurance carrier. We appreciate the opportunity to service you and your employees. Attached, you'll find the Form 5500, Schedule A.

I certify that the attached information for the Form 5500, Schedule A, Part I and Part III, has been taken from our company records and is correct to the best of my knowledge. Mutual of Omaha is providing you with the attached information but makes no representation regarding reporting requirements. Please consult your attorney or other advisor as to your reporting obligations.

For questions, please contact your dedicated Customer Service team or call 1-800-655-5142.

Sincerely,

Nancy A. Sinnett

Nancy A. Sinnett
Vice President
Finance Operations

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SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

ADVANCED BLENDING SOLUTIONS
WALLACE, MI

Name of Carrier:	United of Omaha Life Insurance Company - NAIC Code 69868		
EIN Number:	47-0322111		
Group Identification Number:	G000B8Y2	**Data for Period:**	01-01-2024 to 01-01-2025
Legacy Group ID:	GLUG0B8Y2		
Type of Contract:	NON-RETENTION		

Benefits Provided	Persons Covered
Life & AD&D	109

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
R & R INSURANCE SERVICES INC N14W23900 STONE RIDGE DR WAUKESHA, WI 53188	0	203	Other Compensation	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 3,333

Memo Items: Benefit Charges – Claims Paid 0
Administrative Service Fees 0

Group Office: CHICAGO

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

ADVANCED BLENDING SOLUTIONS
WALLACE, MI

Name of Carrier:	United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number:	47-0322111
Group Identification Number:	G000B8Y2
Legacy Group ID:	GUC 0B8Y2
Type of Contract:	NON-RETENTION

Data for Period: 01-01-2024 to 01-01-2025

Benefits Provided	Persons Covered
ShortTerm Disability Voluntary	50

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
R & R INSURANCE SERVICES INC N14W23900 STONE RIDGE DR WAUKESHA, WI 53188	0	997	Other Compensation	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 17,527

Memo Items: Benefit Charges – Claims Paid 0
Administrative Service Fees 0

Group Office: CHICAGO

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

ADVANCED BLENDING SOLUTIONS
WALLACE, MI

Name of Carrier:	United of Omaha Life Insurance Company - NAIC Code 69868		
EIN Number:	47-0322111		
Group Identification Number:	G000B8Y2	**Data for Period:**	01-01-2024 to 01-01-2025
Legacy Group ID:	GUDE0B8Y2		
Type of Contract:	NON-RETENTION		

Benefits Provided	Persons Covered
Critical Illness Voluntary	5

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
R & R INSURANCE SERVICES INC N14W23900 STONE RIDGE DR WAUKESHA, WI 53188	93		Agent or Broker of Record	3
R & R INSURANCE SERVICES INC N14W23900 STONE RIDGE DR WAUKESHA, WI 53188	0	51	Other Compensation	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 930

Memo Items: Benefit Charges – Claims Paid 0
Administrative Service Fees 0

Group Office: CHICAGO

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

ADVANCED BLENDING SOLUTIONS
WALLACE, MI

Name of Carrier:	United of Omaha Life Insurance Company - NAIC Code 69868		
EIN Number:	47-0322111		
Group Identification Number:	G000B8Y2	**Data for Period:**	01-01-2024 to 01-01-2025
Legacy Group ID:	GUDH0B8Y2		
Type of Contract:	NON-RETENTION		

Benefits Provided	Persons Covered
Accident only Voluntary	23

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
R & R INSURANCE SERVICES INC N14W23900 STONE RIDGE DR WAUKESHA, WI 53188	0	270	Other Compensation	3
R & R INSURANCE SERVICES INC N14W23900 STONE RIDGE DR WAUKESHA, WI 53188	699		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 4,657

Memo Items: Benefit Charges – Claims Paid 0
Administrative Service Fees 0

Group Office: CHICAGO

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

ADVANCED BLENDING SOLUTIONS
WALLACE, MI

Name of Carrier:	United of Omaha Life Insurance Company - NAIC Code 69868		
EIN Number:	47-0322111		
Group Identification Number:	G000B8Y2	**Data for Period:**	01-01-2024 to 01-01-2025
Legacy Group ID:	GUPR0B8Y2		
Type of Contract:	NON-RETENTION		

Benefits Provided	Persons Covered
Long Term Disability Voluntary	32

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
R & R INSURANCE SERVICES INC N14W23900 STONE RIDGE DR WAUKESHA, WI 53188	0	654	Other Compensation	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 11,746

Memo Items: Benefit Charges – Claims Paid 0
Administrative Service Fees 0

Group Office: CHICAGO

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

ADVANCED BLENDING SOLUTIONS
WALLACE, MI

Name of Carrier:	United of Omaha Life Insurance Company - NAIC Code 69868		
EIN Number:	47-0322111		
Group Identification Number:	G000B8Y2	**Data for Period:**	01-01-2024 to 01-01-2025
Legacy Group ID:	GVTL0B8Y2		
Type of Contract:	NON-RETENTION		

Benefits Provided	Persons Covered
Life & AD&D Voluntary	26

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
R & R INSURANCE SERVICES INC N14W23900 STONE RIDGE DR WAUKESHA, WI 53188	1,786		Agent or Broker of Record	3
R & R INSURANCE SERVICES INC N14W23900 STONE RIDGE DR WAUKESHA, WI 53188	0	597	Other Compensation	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 11,905

Memo Items: Benefit Charges – Claims Paid 0
Administrative Service Fees 0

Group Office: CHICAGO