

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, 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, C If the plan is a collectively-bargained plan, check here, D Check box if filing under: Form 5558, automatic extension, special extension, the DFVC program, 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: R CLUB CHILD CARE INC GROUP BENEFIT PLAN
1b Three-digit plan number (PN): 506
1c Effective date of plan: 01/01/2024
2a Plan sponsor's name (employer, if for a single-employer plan): R CLUB CHILD CARE INC
2b Employer Identification Number (EIN): 59-1704870
2c Plan Sponsor's telephone number: 727-578-5437
2d Business code (see instructions): 624410

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

|   |  |     |
|---|--|-----|
| <b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor  | <b>3b</b> Administrator's EIN              |     |
|   | <b>3c</b> Administrator's telephone number |     |
| <b>4</b> 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:<br><b>a</b> Sponsor's name<br><b>c</b> Plan Name  | <b>4b</b> EIN                              |     |
|   | <b>4d</b> PN                               |     |
| <b>5</b> Total number of participants at the beginning of the plan year   | <b>5</b>                                   | 150 |
| <b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).<br><b>a(1)</b> Total number of active participants at the beginning of the plan year .....<br><b>a(2)</b> Total number of active participants at the end of the plan year .....<br><b>b</b> Retired or separated participants receiving benefits.....<br><b>c</b> Other retired or separated participants entitled to future benefits .....<br><b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....<br><b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....<br><b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....<br><b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....<br><b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....<br><b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested..... | <b>6a(1)</b>                               | 150 |
|   | <b>6a(2)</b>                               | 318 |
|   | <b>6b</b>                                  |     |
|   | <b>6c</b>                                  |     |
|   | <b>6d</b>                                  | 318 |
|   | <b>6e</b>                                  |     |
|   | <b>6f</b>                                  | 318 |
|   | <b>6g(1)</b>                               |     |
| <b>6g(2)</b>  |  |     |
| <b>6h</b>   |  |     |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....  | <b>7</b>                                   |     |

**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 4H

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

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

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

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

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**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.

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**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 \_\_\_\_\_

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|   |  |  |
|---|--|--|
| <p><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p> | <p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></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><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p> |
|---|--|--|

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

|   |  |            |
|---|--|------------|
| <b>A</b> Name of plan<br><b>R CLUB CHILD CARE INC GROUP BENEFIT PLAN</b>                      | <b>B</b> Three-digit plan number (PN) ▶                            | <b>506</b> |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><b>R CLUB CHILD CARE INC</b> | <b>D</b> Employer Identification Number (EIN)<br><b>59-1704870</b> |            |

**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 HEALTHCARE 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     |
| 36-2739571 | 79413         | 930268                                | 318   | 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.

|  |                                      |
|--|--------------------------------------|
| <b>(a)</b> Total amount of commissions paid<br><b>7528</b> | <b>(b)</b> Total amount of fees paid |
|--|--------------------------------------|

**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  
**BROWN & BROWN OF FL INC PINELLAS**      **140 FOUNTAIN PKWY N**  
**STE 600**  
**ST PETERSBURG, FL 33716**

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
|   | (c) Amount                      | (d) Purpose |                       |
| <b>7528</b>                                   |                                 |             | <b>3</b>              |

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

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

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

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

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

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

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

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

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

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

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

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

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

|  |          |  |
|--|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....    | <b>5</b> |  |

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

**b** Premiums paid to carrier ..... **6b** 1913441

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

**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:

|          |  |                 |         |         |
|----------|--|-----------------|---------|---------|
| <b>a</b> | Premiums: (1) Amount received .....  | <b>9a(1)</b>    | 2021777 |         |
|          | (2) Increase (decrease) in amount due but unpaid .....   | <b>9a(2)</b>    |         |         |
|          | (3) Increase (decrease) in unearned premium reserve .....  | <b>9a(3)</b>    |         |         |
|          | (4) Earned ((1) + (2) - (3)) .....   | <b>9a(4)</b>    |         | 2021777 |
| <b>b</b> | Benefit charges (1) Claims paid .....  | <b>9b(1)</b>    |         |         |
|          | (2) Increase (decrease) in claim reserves .....  | <b>9b(2)</b>    |         |         |
|          | (3) Incurred claims (add (1) and (2)) .....  | <b>9b(3)</b>    |         |         |
|          | (4) Claims charged .....   | <b>9b(4)</b>    |         |         |
| <b>c</b> | Remainder of premium: (1) Retention charges (on an accrual basis) --   |                 |         |         |
|          | (A) Commissions .....  | <b>9c(1)(A)</b> | 26525   |         |
|          | (B) Administrative service or other fees .....   | <b>9c(1)(B)</b> |         |         |
|          | (C) Other specific acquisition costs .....   | <b>9c(1)(C)</b> |         |         |
|          | (D) Other expenses .....   | <b>9c(1)(D)</b> |         |         |
|          | (E) Taxes .....  | <b>9c(1)(E)</b> |         |         |
|          | (F) Charges for risks or other contingencies .....   | <b>9c(1)(F)</b> |         |         |
|          | (G) Other retention charges .....  | <b>9c(1)(G)</b> | 4041    |         |
|          | (H) Total retention .....  | <b>9c(1)(H)</b> |         | 30566   |
|          | (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) ..... | <b>9c(2)</b>    |         |         |
| <b>d</b> | Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....   | <b>9d(1)</b>    |         |         |
|          | (2) Claim reserves .....   | <b>9d(2)</b>    |         |         |
|          | (3) Other reserves .....   | <b>9d(3)</b>    |         |         |
| <b>e</b> | Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....  | <b>9e</b>       |         |         |

**10** Nonexperience-rated contracts:

|          |  |            |  |
|----------|--|------------|--|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> |  |
| <b>b</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. .... | <b>10b</b> |  |

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><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p> | <p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></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><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p> |
|---|--|--|

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

|   |  |                   |
|---|--|-------------------|
| <p><b>A</b> Name of plan<br/><b>R CLUB CHILD CARE INC GROUP BENEFIT PLAN</b></p>                      | <p><b>B</b> Three-digit plan number (PN) ▶</p>                             | <p><b>506</b></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>R CLUB CHILD CARE INC</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>59-1704870</b></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  
**FIDELITY SECURITY 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     |
| 43-0949844 | 71870         | 10113001001                           | 154   | 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><b>(a)</b> Total amount of commissions paid<br/><b>1485</b></p> | <p><b>(b)</b> Total amount of fees paid</p> |
|--|---|

**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid  
**BROWN & BROWN INSURANCE SERVICES**      **83 PARK PLACE BLVD**  
**STE 101**  
**CLEARWATER, FL 33716**

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
|   | (c) Amount                      | (d) Purpose |                       |
| 1485  |                                 |             | 3                     |

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

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

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

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

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

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

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

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

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

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

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

|                |  |
|----------------|--|
| <b>Part II</b> | <b>Investment and Annuity Contract Information</b><br>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. |
|----------------|--|

|  |          |  |
|--|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....    | <b>5</b> |  |

**6** Contracts With Allocated Funds:

|  |           |  |
|--|-----------|--|
| <b>a</b> State the basis of premium rates ▶  |           |  |
| <b>b</b> Premiums paid to carrier .....  | <b>6b</b> |  |
| <b>c</b> Premiums due but unpaid at the end of the year .....  | <b>6c</b> |  |
| <b>d</b> 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. ....<br>Specify nature of costs ▶ | <b>6d</b> |  |
| <b>e</b> Type of contract: (1) <input type="checkbox"/> individual policies                      (2) <input type="checkbox"/> group deferred annuity<br>(3) <input type="checkbox"/> other (specify) ▶         |           |  |
| <b>f</b> 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)

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

**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:

|          |  |                 |                 |       |
|----------|--|-----------------|-----------------|-------|
| <b>a</b> | Premiums: (1) Amount received .....  | <b>9a(1)</b>    |                 | 14912 |
|          | (2) Increase (decrease) in amount due but unpaid .....   | <b>9a(2)</b>    |                 |       |
|          | (3) Increase (decrease) in unearned premium reserve .....  | <b>9a(3)</b>    |                 |       |
|          | (4) Earned ((1) + (2) - (3)) .....   |                 | <b>9a(4)</b>    | 14912 |
| <b>b</b> | Benefit charges (1) Claims paid .....  | <b>9b(1)</b>    |                 |       |
|          | (2) Increase (decrease) in claim reserves .....  | <b>9b(2)</b>    |                 |       |
|          | (3) Incurred claims (add (1) and (2)) .....  |                 | <b>9b(3)</b>    |       |
|          | (4) Claims charged .....   |                 | <b>9b(4)</b>    |       |
| <b>c</b> | Remainder of premium: (1) Retention charges (on an accrual basis) --   |                 |                 |       |
|          | (A) Commissions .....  | <b>9c(1)(A)</b> |                 |       |
|          | (B) Administrative service or other fees .....   | <b>9c(1)(B)</b> |                 |       |
|          | (C) Other specific acquisition costs .....   | <b>9c(1)(C)</b> |                 |       |
|          | (D) Other expenses .....   | <b>9c(1)(D)</b> |                 |       |
|          | (E) Taxes .....  | <b>9c(1)(E)</b> |                 |       |
|          | (F) Charges for risks or other contingencies .....   | <b>9c(1)(F)</b> |                 |       |
|          | (G) Other retention charges .....  | <b>9c(1)(G)</b> |                 |       |
|          | (H) Total retention .....  |                 | <b>9c(1)(H)</b> |       |
|          | (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) ..... |                 | <b>9c(2)</b>    |       |
| <b>d</b> | Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....   |                 | <b>9d(1)</b>    |       |
|          | (2) Claim reserves .....   |                 | <b>9d(2)</b>    |       |
|          | (3) Other reserves .....   |                 | <b>9d(3)</b>    |       |
| <b>e</b> | Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....  |                 | <b>9e</b>       |       |

**10** Nonexperience-rated contracts:

|          |  |            |  |
|----------|--|------------|--|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> |  |
| <b>b</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. .... | <b>10b</b> |  |

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. ▶



May 16, 2025

Maria Climes  
4140 49th Street  
St. Petersburg FL 33709

Dear Valued Customer:

Employee Retirement Income Security Act of 1974 (ERISA)

We have enclosed information that you may need for completing the 5500 Form Schedule A. This information reflects compensation paid to your agent or consultant for the plan year that recently ended for the coverage you have with us.

We are reporting any base commissions, bonuses and other types of compensation paid in relation to the plan during the plan year. Please note that only base commissions are included in the specific calculation of your premium or administrative service fee. Bonus and other non-base commission payments are not directly included in the determination of your premium or administrative service fee. Bonus payments may be based on the recipient's combined block of business and are allocated to cases according to their contribution to the amount earned.

**IMPORTANT NOTE:** The enclosed information may be divided into two reports. Some customers may receive a 5500 Addendum Report in addition to the standard 5500 Schedule A report form. The 5500 Addendum Report itemizes bonus compensation and payments that were processed manually separately. **If you have received the 5500 Addendum Report as well as the standard 5500 Schedule A report form, you will need to add the amounts in the Total line of the 5500 Addendum Report to the amount found in the standard 5500 Schedule A report form.**

Should you have any questions related to this information, please contact your agent, consultant, or the UnitedHealthcare Strategic Account Executive assigned to your case.

I hereby certify that to the best of my knowledge, information or belief at this time, and based upon information provided by duly authorized personnel, the foregoing statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate.

Thank you.

Sincerely,  
The UnitedHealthcare Team

**Schedule A (Form 5500) Parts I and III  
Insurance Information Certified by Carrier  
Department of Labor Pension and Welfare Benefits**

**Principal Address:  
4140 49th Street  
St. Petersburg FL 33709**

**A) Name of Plan:  
R'Club Child Care, Inc.**

**Part I Information Concerning Insurance Contract Coverage, Fee, and Commissions**

**1. Coverage**

**(a) Name of Insurance carrier:** UnitedHealthcare Insurance Company

**(b) EIN: 36-2739571 (c) NAIC code: 79413 (d) Contract or identification number:** 930268

**(e) Approximate number of persons covered at the end of policy or contract year:** \* 318

**\* If the policy holder determines that they have a more accurate count, they should use their figure.**

**Policy or Contract year (f) from:** 01/01/2024 **(g) to:** 12/31/2024

**2. Insurance fees and commissions paid to agents, brokers, and other persons**

**Totals Total amount of commissions paid:** \$7,528.80 **Total fees paid/amount:** \$0.00

**(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid:**

BROWN & BROWN OF FL INC-PINELLAS DIV  
140 FOUNTAIN PKWY N STE 600  
ST PETERSBURG FL 33716-1274

**(b) Amount of commissions paid:** \$7,528.80

**(c) Fees paid / Amount:** \$0.00

**(d) Fees paid/Purpose:** N/A

**(e) Organizational Code:** 3

**Part III Welfare Benefit Contract Information**

**7. Benefit and contract type**

**(a) Health**

**9. Non experience-rated contracts**

**(a) Total premiums or subscription charges paid to carrier:** \$1,913,441.56

**Total Fees paid to carrier:** \$0.00

**(b) Additional costs incurred by carrier, service, or other  
Organization not reported in Part 1, item 2 above:** \$0.00

**Specify Nature of cost:**



# Vision Insurance Information For Form 5500

Information Compiled By: EyeMed Vision Care on behalf of the Fidelity Security Life Insurance Company

| Report Start Date | Report End Date |
|-------------------|-----------------|
| 1/1/24            | 12/31/24        |

Report Generated: 2/5/25

**Payments Received by carrier from plan or plan sponsor:**

| Name of Plan      | Contract or ID # | Enrollment Group              | Approximate number of subscribers covered at end of policy or contract year: | Approximate number of subscribers and dependents covered at end of policy or contract year: | EIN       | NAIC  |               | Amount             |
|-------------------|------------------|-------------------------------|--|---|-----------|-------|---------------|--------------------|
| R'CLUB CHILD CARE | 10113001001      | R'CLUB CHILD CARE, INC.       | 154  | 221   | 430949844 | 71870 |               | \$14,912.75        |
| R'CLUB CHILD CARE | 10113011001      | R'CLUB CHILD CARE, INC. COBRA | 0  | 0   | 430949844 | 71870 |               | \$0.00             |
|                   |                  |                               |  |   |           |       | <b>Total:</b> | <b>\$14,912.75</b> |

**Commissions or fees paid by carrier to agents, brokers or other persons:**

| Payee Name                               | Contract or ID # | Address Line 1                   | City           | State | Zip Code |  | Amount        |                   |
|--|------------------|----------------------------------|----------------|-------|----------|--|---------------|-------------------|
| Brown & Brown - Clearwater, FL 59-069192 | 10113001001      | 140 Fountain Pkwy., N., Ste. 600 | St. Petersburg | FL    | 33716    |  | \$506.85      |                   |
| Brown & Brown - Clearwater, FL 59-069192 | 10113001001      | 83 Park Place Blvd Ste 101       | Clearwater     | FL    | 33759    |  | \$371.69      |                   |
| Brown & Brown Insurance Services, Inc. - | 10113001001      | 140 Fountain Pkwy., N., Ste. 600 | St. Petersburg | FL    | 33716    |  | \$607.04      |                   |
|  |                  |                                  |                |       |          |  | <b>Total:</b> | <b>\$1,485.58</b> |

Note: Payments and applicable fees or commissions related to the plan or plan sponsor, which are not paid and posted within the date range provided above, are not included in this report. Instead, such payments will be included in prior or subsequent Schedule A reporting, as appropriate. Payments and applicable fees or commissions may vary from the carrier's billed amounts.

**R'CLUB CHILD CARE, INC.**  
Contract ID Number 371684  
Coverage Period 01/01/2024-12/31/2024

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

Name of Insurance Carrier: UnitedHealthCare Insurance Company  
EIN Number 36-2739571  
NAIC Number 79413

Insurance Fees and Commissions Paid to General Agents, Brokers or Other Persons

Broker Commissions Paid To:  
BROWN & BROWN OF FL INC-PINELLAS DIV  
83 N PARK PLACE BLVD STE 101  
CLEARWATER, FL 33759

| Commissions Paid   |                   |
|--------------------|-------------------|
| Purpose:           | Broker Commission |
| Amount:            | \$18,997.89       |
| Organization Code: | 3                 |

| 5500 Line 10a Fees Paid |            |
|-------------------------|------------|
| Purpose:                | Admin Fees |
| Amount:                 | \$0.00     |
| Organization Code:      |            |

**Part III Welfare Benefit Contract Information**

**Benefits and Coverage**

|                  | Disability<br>STD | Disability<br>LTD | Basic Life  | Critical<br>Illness | Supplemental<br>Life | Basic AD&D | Hospital<br>Indemnity<br>Product | Voluntary<br>AD&D | Supp Dep<br>life | Accident<br>Protection<br>Plan | TOTAL        |
|------------------|-------------------|-------------------|-------------|---------------------|----------------------|------------|----------------------------------|-------------------|------------------|--------------------------------|--------------|
| Premiums Due     | \$16,844.81       | \$15,088.20       | \$18,705.85 | \$15,095.15         | \$18,517.10          | \$2,301.36 | \$11,412.64                      | -\$392.95         | \$3,998.95       | \$6,765.48                     | \$108,336.59 |
| # of Subscribers | 81                | 85                | 247         | 51                  | 88                   | 247        | 53                               | 29                | 77               | 68                             |              |
| # of Dependents  |                   |                   |             | 44                  |                      |            | 34                               |                   |                  | 52                             |              |

Premiums due and unpaid at the end of the reporting period \$0.00

The above information is certified to help you complete Schedule A, Parts I and III, of the Internal Revenue Service, Department of Labor Annual Return Form 5500 for the last policy year.

Other information needed to complete Schedule A, can be taken from your own records. When making entries on the form we anticipate you will see that such entries are consistent with those used in Part I, and that all applicable boxes are checked under Part III, Number 7.

In most cases, we have been able to provide the actual subscriber and dependent count based on the number of persons covered during the last month of the policy year. However, if you should determine that you have a more accurate count, then please use that figure.