

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: DISABILITY INCOME FOR THE HOME OFFICE EMPLOYEES
1b Three-digit plan number (PN): 501
1c Effective date of plan: 01/01/1967
2a Plan sponsor's name (employer, if for a single-employer plan): AUGUSTAR LIFE INSURANCE COMPANY
2b Employer Identification Number (EIN): 31-0397080
2c Plan Sponsor's telephone number: 513-794-6100
2d Business code (see instructions): 524140

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.

| | | |
|---|--|-----|
| 3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor | 3b Administrator's EIN | |
| | 3c Administrator's telephone number | |
| 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name | 4b EIN | |
| | 4d PN | |
| 5 Total number of participants at the beginning of the plan year | 5 | 610 |
| 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested..... | 6a(1) | 610 |
| | 6a(2) | 544 |
| | 6b | |
| | 6c | |
| | 6d | 544 |
| | 6e | |
| | 6f | 544 |
| | 6g(1) | |
| 6g(2) | | |
| 6h | | |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | 7 | |

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

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

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

| | | |
|---|--|--|
| <p>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> |
|---|--|--|

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

| | | |
|---|--|-------------------|
| <p>A Name of plan DISABILITY INCOME FOR THE HOME OFFICE EMPLOYEES</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 AUGUSTAR LIFE INSURANCE COMPANY</p> | <p>D Employer Identification Number (EIN) 31-0397080</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
HARTFORD LIFE AND ACCIDENT

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 06-0838648 | 70815 | 805774G | 544 | 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 | 0 |

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

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

| (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 | |
| | | | |

(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) | | 163884 |
| | (2) Increase (decrease) in claim reserves | 9b(2) | | |
| | (3) Incurred claims (add (1) and (2)) | | 9b(3) | 163884 |
| | (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 | | 276421 |
| 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. ▶



The Hartford
 GBD Producer Services
 P.O.Box 2999
 Hartford, CT 06104-2999

March 24, 2025

MB 01 001140 56292 H 7 B



CONSTELLATION INSURANCE
 JARLYN RATLIFF, MBA
 ONE FINANCIAL WAY
 CINCINNATI OH 45242-5800

Dear Policyholder:

We've attached your certified Annual Statement of Premiums and Producer Compensation group benefits summary. The summary is useful when completing and filing an IRS Form 5500 Schedule A. The Hartford certifies the accuracy and completeness of the information provided.

To help you better understand your statement, we've defined some of the terms used in the report.

| TERM: | DEFINITION: |
|--|--|
| Premiums | Payments paid and applied during the policy year |
| Commissions | Base paid to your insurance producer on premiums received and applied during the policy year |
| Fees Record as "Fees" on IRS Form 5500 Schedule A | Payments to your insurance producer for administrative or other services related to your policy including General Agent override compensation |
| Bonus Paid Record as "Fees" on IRS Form 5500 Schedule A | Contingent compensation (cash or non-cash) payable to producers on all policies that were considered in determining the producer's eligibility for bonus payments and/or the actual calculation of any such bonus payment |
| Additional Compensation Record as "Fees" on IRS Form 5500 Schedule A | Non-contingent compensation (cash or non-cash) payable to producers on all policies that were considered in determining the producer's eligibility for additional compensation and/or the actual calculation of any such additional compensation |

We appreciate your business and look forward to serving your group benefit needs. Please contact your Hartford representative or call Customer Service at (800) 523-2233 if you have any questions. You can also e-mail us at: gbdcommissions@hartfordlife.com.

Sincerely,

Jonathan Pintoff
 Assistant Vice President
 Service Operations
 P.O. Box 2999
 Hartford, CT 06104-2999

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting company Hartford Life and Accident Insurance Company under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at www.thehartford.com. The Hartford is the administrator for certain group benefits business written Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). © 2022 The Hartford

001140 1/3

2505

The Hartford
 Group Benefits Division
 Annual Statement of Premiums and Producer Compensation



For: CONSTELLATION INSURANCE
 Page 1 of 2

Policyholder and Address

CONSTELLATION INSURANCE
 ONE FINANCIAL WAY
 CINCINNATI OH 45242

Plan/Policy Year - 01/01/2024 to 12/31/2024

| Name of Insurance Carrier | EIN | NAIC Code | Policy Number |
|----------------------------|------------|-----------|---------------|
| HARTFORD LIFE AND ACCIDENT | 06-0838648 | 70815 | 805774G |

Premium was applied as follows during the Plan/Policy Year -

| Policy Number | Type of Benefit | Premium Applied | Approximate # of Lives Covered |
|---------------|-----------------|---------------------|--------------------------------|
| 805774G | LIFE-BDEP | \$6,406.52 | 446 |
| 805774G | LIFE-BTRM | \$288,119.77 | 931 |
| 805774G | LTD-ABIL | \$276,421.21 | 529 |
| | Total | \$570,947.50 | |

Continued on Next Page

001140 2/3



2305

The Hartford
Group Benefits Division
Annual Statement of Premiums and Producer Compensation



For: CONSTELLATION INSURANCE

Page 2 of 2

Insurer paid the following on behalf of coverages shown during the Plan/Policy Year -

| Producer and Address | Org Code | Policy Number | Commissions Paid | Fees Paid | (1) Bonus Paid | (2) Additional Compensation Paid |
|---|-----------------|--------------------------|-------------------------|------------------|-----------------------|---|
| HOME OFFICE DIRECT ONE HARTFORD PLAZA HARTFORD CT 06155 | 3 | 805774-OGL 805774-GLT | \$0.00 \$0.00 | \$0.00 \$0.00 | \$0.00 \$0.00 | \$0.00 \$0.00 |
| | | Total | \$0.00 | \$0.00 | \$0.00 | \$0.00 |

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(1) Bonus Paid represents an allocation of contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such bonus payment. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

(2) Additional Compensation represents an allocation of non-contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such additional compensation. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

The Hartford compensates producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation, including contingent commission and other non-cash awards. Incentive compensation is based upon a variety of factors that may include the level of premium written, retention and growth of premium, overall profitability, or other performance measures. Some of our producers elect not to accept some or all forms of compensation from The Hartford. Please direct specific questions about your insurance producer's compensation to your producer.