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 03/01/2024 and ending 02/28/2025

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.)
- ☒ 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
GOOD SHEPHERD COMMUNITY CARE HEALTH & WELFARE PLAN

1b Three-digit plan number (PN) ▶ 503

1c Effective date of plan 03/01/2021

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)
HOSPICE OF THE GOOD SHEPHERD, INC.

160 WELLS AVENUE
NEWTON, MA 02459

2b Employer Identification Number (EIN) 04-2655734

2c Plan Sponsor's telephone number 617-969-6130

2d Business code (see instructions) 621498

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.	09/05/2025	MEREDITH TANSEY
	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:

a Sponsor's name

c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	119
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)**	118
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	134
b	Retired or separated participants receiving benefits	**6b**	2
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	136
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
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:

4A 4B 4D 4E 4F 4H 4Q

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] 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)** [X] 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 3
- **(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 03/01/2024 and ending 02/28/2025

A Name of plan
GOOD SHEPHERD COMMUNITY CARE HEALTH & WELFARE PLAN

B Three-digit plan number (PN) ▶ 503

C Plan sponsor's name as shown on line 2a of Form 5500
HOSPICE OF THE GOOD SHEPHERD, INC.

D Employer Identification Number (EIN)
04-2655734

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
HARVARD PILGRIM HEALTH CARE

(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
04-2452600	96911	C77232	85	03/01/2024	02/28/2025

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
51360	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

BROWN & BROWN INSURANCE SERVICES IN
300 N BEACH ST
DAYTONA, FL 32114

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
30760			3

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

BROWN & BROWN OF MASSACHUSETTS
980 WASHINGTON STREET
SUITE 325
DEDHAM, MA 02026

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
20600			3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	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	0
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)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
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)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

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** [X] 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** [X] HMO contract
- **k** [X] 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)**	0
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)**	0
(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)**	0
(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**	1676836
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 [X] No

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

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 03/01/2024 and ending 02/28/2025

A Name of plan
GOOD SHEPHERD COMMUNITY CARE HEALTH & WELFARE PLAN

B Three-digit plan number (PN) ▶ 503

C Plan sponsor's name as shown on line 2a of Form 5500
HOSPICE OF THE GOOD SHEPHERD, INC.

D Employer Identification Number (EIN)
04-2655734

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
USABLE LIFE

(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
71-0505232	94358	50002092	134	03/01/2024	02/28/2025

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
16374	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

INDIGO INSURANCE SERVICES
100 FRONT STREET, 20TH FLOOR
WORCESTER, MA 01608

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
16374			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	

(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	0
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)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
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)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

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** [X] Life insurance
- **e** [X] Temporary disability (accident and sickness)
- **f** [X] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [X] Other (specify) ▶ 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)**	0
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)**	0
(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)**	0
(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**	72866
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. Specify nature of costs.			**10b**	

Part IV Provision of Information

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

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

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 03/01/2024 and ending 02/28/2025

A Name of plan
GOOD SHEPHERD COMMUNITY CARE HEALTH & WELFARE PLAN

B Three-digit plan number (PN) ▶ 503

C Plan sponsor's name as shown on line 2a of Form 5500
HOSPICE OF THE GOOD SHEPHERD, INC.

D Employer Identification Number (EIN)
04-2655734

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
BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, INC.

(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	Policy or contract year (g) To
04-0145815	53228	0206193	223	03/01/2024	02/28/2025

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
5126	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

BROWN & BROWN OF MASSACHUSETTS
980 WASHINGTON STREET
SUITE 325
DEDHAM, MA 02026

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
5126			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	Fees and other commissions paid (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)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
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)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

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** [X] Dental
- **c** [X] 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)	0
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)	0
(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)	0
(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	106226
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 [X] No

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

Harvard Pilgrim Health Care

1 Wellness Way
Canton, MA 02021
781.612.1000
harvardpilgrim.org

06/20/2025

Hospice of the Good Shepherd Inc
160 Wells Avenue
Newton, MA 02459

RE: Form 5500 Schedule A Supporting Information

Dear Employer:

Enclosed for your reference is the supporting information Harvard Pilgrim Health Plan is required by the Employee Retirement Income Security Act of 1974 (ERISA) section 103 (a)(2) to provide you so that you can complete your Form 5500 Schedule A filing, if applicable.

As you review the following information, please note this is applicable only to employers who are represented by a broker:

The "Commissions Paid" to your broker during your contract year includes all monthly commissions. The "Other Compensation Paid" may include annual bonuses (such as new business and/or retention bonuses), as well as other items awarded to your broker that are specifically attributable to the sale and/or retention of your business (additional compensation).

Monthly commissions are directly allocated to each employer group, either as a percentage of premiums received or as a flat rate per subscriber. If your broker represents more than one employer group and receives a bonus, the bonus will be prorated across the broker's entire book of business based upon percentage of premiums received during the calendar year. The dollar equivalent of any additional compensation will be prorated among any employer groups that contributed to the eligibility for the additional compensation.

Harvard Pilgrim Health Plan certifies that the information provided pursuant to 29 C.F.R. Section 2520.103-5 is complete and accurate. If you have any questions, please contact the Broker/Employer Service Teams at 800-637-4751 or via email at Myserviceteam@point32health.org with hours of operation of 8:30-5 M,T,T,F and 10-5 Wednesday.

Sincerely,

Broker Compensation Department

Harvard Pilgrim Health Care

1 Wellness Way
Canton, MA 02021
781.612.1000
harvardpilgrim.org

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-800-208-1221 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-208-1221 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-800-208-1221 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-208-1221（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-800-208-1221 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-208-1221 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللُّغة العربية ، خدمات المساعدة اللُّغوية متوفرة لك مجانا. **إتصل على 1 -800-208-1221 (TTY: 711)**

ខ្មែរ (Cambodian) ប្រសូមជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, ឱ្យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ជូរ ទូរស័ព្ទ 1-800-208-1221 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-208-1221 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-208-1221 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-208-1221 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-800-208-1221 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-208-1221 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-800-208-1221 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-800-208-1221 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-208-1221 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-208-1221 (TTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

(Continued)

Harvard Pilgrim Health Care

1 Wellness Way
Canton, MA 02021
781.612.1000
harvardpilgrim.org

General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Harvard Pilgrim Health Care

1 Wellness Way
Canton, MA 02021
781.612.1000
harvardpilgrim.org

From 5500 Schedule A Supporting Information
This information is provided pursuant to ERISA Section 103(a)(2)

Issue Date: 06/20/2025

Customer Number: C77232

Group Name: Hospice of the GS HMO BB 1500

Contract Year: 03/01/2024 - 02/28/2025

Name of Insurance Carrier: HARVARD PILGRIM HEALTH CARE

Carrier NAIC Number: 96911 **Carrier EIN Number:** 04-2452600

Type of Benefit: HEALTH

Approximate Number of Members at End of Contract Year: 85

Total Premiums Received by Carrier in Contract Year: $724,203.47

Broker Compensation:

Broker Name	Broker Address	Commissions Paid	Other Compensations Paid	Total Compensations Paid
BROWN & BROWN INSURANCE SERVICES INC	300 N Beach Street,Daytona Beach,FL,32114	$13,792.67	$0.00	$13,792.67
BROWN & BROWN OF MASSACHUSETTS LLC	MASSACHUSETTS, LLC,980 WASHINGTON STREET,DEDHAM,MA,02026	$9,236.96	$0.00	$9,236.96
	Total	$23,029.63	$0.00	$23,029.63

Group and Customer Account numbers covered under this form: 178823 1788230000

1 Wellness Way
Canton, MA 02021
781.612.1000
harvardpilgrim.org

From 5500 Schedule A Supporting Information
This information is provided pursuant to ERISA Section 103(a)(2)

Issue Date: 06/20/2025

Customer Number: C77232

Group Name: Hospice of the GS HMO BB 2000

Contract Year: 03/01/2024 - 02/28/2025

Name of Insurance Carrier: HARVARD PILGRIM HEALTH CARE

Carrier NAIC Number: 96911 **Carrier EIN Number:** 04-2452600

Type of Benefit: HEALTH

Approximate Number of Members at End of Contract Year: 66

Total Premiums Received by Carrier in Contract Year: $500,647.63

Broker Compensation:

Broker Name	Broker Address	Commissions Paid	Other Compensations Paid	Total Compensations Paid
BROWN & BROWN INSURANCE SERVICES INC	300 N Beach Street,Daytona Beach,FL,32114	$9,012.68	$0.00	$9,012.68
BROWN & BROWN OF MASSACHUSETTS LLC	MASSACHUSETTS, LLC,980 WASHINGTON STREET,DEDHAM,MA,02026	$6,035.80	$0.00	$6,035.80
	Total	$15,048.48	$0.00	$15,048.48

Group and Customer Account numbers covered under this form: 178824 1788240000

1 Wellness Way
Canton, MA 02021
781.612.1000
harvardpilgrim.org

From 5500 Schedule A Supporting Information
This information is provided pursuant to ERISA Section 103(a)(2)

Issue Date: 06/20/2025

Customer Number: C77232

Group Name: Hospice of the GS PPO BB 2000

Contract Year: 03/01/2024 - 02/28/2025

Name of Insurance Carrier: HARVARD PILGRIM HEALTH CARE

Carrier NAIC Number: 96911 **Carrier EIN Number:** 04-2452600

Type of Benefit: HEALTH

Approximate Number of Members at End of Contract Year: 57

Total Premiums Received by Carrier in Contract Year: $442,814.34

Broker Compensation:

Broker Name	Broker Address	Commissions Paid	Other Compensations Paid	Total Compensations Paid
BROWN & BROWN INSURANCE SERVICES INC	300 N Beach Street,Daytona Beach,FL,32114	$7,918.08	$0.00	$7,918.08
BROWN & BROWN OF MASSACHUSETTS LLC	MASSACHUSETTS, LLC,980 WASHINGTON STREET,DEDHAM,MA,02026	$5,302.74	$0.00	$5,302.74
	Total	$13,220.82	$0.00	$13,220.82

Group and Customer Account numbers covered under this form: 178825 1788250000

1 Wellness Way
Canton, MA 02021
781.612.1000
harvardpilgrim.org

From 5500 Schedule A Supporting Information
This information is provided pursuant to ERISA Section 103(a)(2)

Issue Date: 06/20/2025

Customer Number: C77232

Group Name: Hospice of the GS PPO BB 2000/COB

Contract Year: 03/01/2024 - 02/28/2025

Name of Insurance Carrier: HARVARD PILGRIM HEALTH CARE

Carrier NAIC Number: 96911 **Carrier EIN Number:** 04-2452600

Type of Benefit: HEALTH

Approximate Number of Members at End of Contract Year:

Total Premiums Received by Carrier in Contract Year: $9,170.29

Broker Compensation:

Broker Name	Broker Address	Commissions Paid	Other Compensations Paid	Total Compensations Paid
BROWN & BROWN INSURANCE SERVICES INC	300 N Beach Street,Daytona Beach,FL,32114	$36.57	$0.00	$36.57
BROWN & BROWN OF MASSACHUSETTS LLC	MASSACHUSETTS, LLC,980 WASHINGTON STREET,DEDHAM,MA,02026	$24.49	$0.00	$24.49
	Total	$61.06	$0.00	$61.06

Group and Customer Account numbers covered under this form: 178825 1788250001

Blue Cross Blue Shield of Massachusetts, Inc.

FULLY INSURED #5500A WORKSHEET

ACCOUNT NAME: Good Shepherd Community Care
ACCOUNT #: 0206193
PERIOD: 03/01/2024 - 02/28/2025 @ 04/30/2025
NAIC CODE: 53228
EIN CODE: 04-1045815

	MEDICAL	DENTAL	SENIOR	VISION	
LAST MONTH OF PERIOD ENROLLMENT					
Employees	0	119	0	90	
Employee & Dependents	0	223	0	153	
PREMIUM					
Total Premium	$0	$97,016	$0	$9,210	$106,226
BENEFIT CHARGES					
Incurred Claims	$0	$78,152	$0	$5,133	
Incurred But Not Reported	$0	$1,172	$0	$41	
Claims Charged	$0	$79,325	$0	$5,174	
RETENTION ALLOCATION					
Base Commission	$0	$4,205	$0	$921	
Taxes	$0	$0	$0	$0	
Other Retention Charges	$0	$13,486	$0	$3,115	

Copies: 1 - Sales Executive, 1 - File Copy, 1 - Group

The above information is intended to help you complete the Form 5500, Schedule A. If you require additional information please contact your representative at BCBSMA.

COMMISSIONS AND BONUS BREAKDOWN

ACCOUNT NAME: Good Shepherd Community Care
ACCOUNT #: 0206193
PERIOD: 03/01/2024 - 02/28/2025 @ 04/30/2025
NAIC CODE: 53228
EIN CODE: 04-1045815

	MEDICAL	DENTAL	SENIOR	VISION	
COMMISSION BREAKDOWN					
BROWN & BROWN OF MA LLC	$0.00	$978.95	$0.00	$128.92	
Brown & Brown Insurance Services, Inc	$0.00	$3,226.35	$0.00	$792.04	
		$4,205.30		$920.96	$5,126.26

Copies: 1 - Sales Executive, 1 - File Copy, 1 - Group

The above information is intended to help you complete the Form 5500, Schedule A and C. If you require additional information information please contact your representative at BCBSMA.

USAble Life

Statement of Insurance Data for Schedule A (Form 5500)

Name of Plan:	**HOSPICE OF THE GOOD SHEPHERD DBA GOOD SHEPHERD COMMUNITY CARE**
Name of Insurance Carrier:	**USAble Life**
Carrier Employer Identification Number (EIN):	**71-0505232**
NAIC Code:	**94358**
Contract or Identification Number:	50002092
Approximate number of persons covered at end of policy or current year:	134
Policy or Contract Year:	3/1/2024 - 2/28/2025
Benefit and Contract Type:	Group Term Life Accidental Death & Dismemberment
Total Amount of Commissions and Fees Paid:	$7,367.98
Premiums Paid to Carrier:	$36,839.99
Premiums Due but Unpaid at End of Year:	

Persons Receiving Commissions:

Name and Address of the agent, broker, or other person to whom commissions or fees were paid:	Total amount of Commissions Paid	Total Fees Paid/Additional Compensation
INDIGO INSURANCE SERVICES 100 FRONT STREET 20TH FLOOR WORCESTER, MA 01608	$7,367.98	

This statement contains the data necessary for completion of your Schedule A (Form 5500) .This is not a representation of the actual Schedule A form. Please contact either a financial advisor or internal Tax Department for assistance.

USAble Life

Statement of Insurance Data for Schedule A (Form 5500)

Name of Plan:	**HOSPICE OF THE GOOD SHEPHERD DBA GOOD SHEPHERD COMMUNITY CARE**
Name of Insurance Carrier:	**USAble Life**
Carrier Employer Identification Number (EIN):	**71-0505232**
NAIC Code:	**94358**
Contract or Identification Number:	50002092
Approximate number of persons covered at end of policy or current year:	51
Policy or Contract Year:	3/1/2024 - 2/28/2025
Benefit and Contract Type:	Voluntary Accidental Death & Dismemberment
Total Amount of Commissions and Fees Paid:	$231.34
Premiums Paid to Carrier:	$925.40
Premiums Due but Unpaid at End of Year:	

Persons Receiving Commissions:

Name and Address of the agent, broker, or other person to whom commissions or fees were paid:	Total amount of Commissions Paid	Total Fees Paid/Additional Compensation
INDIGO INSURANCE SERVICES 100 FRONT STREET 20TH FLOOR WORCESTER, MA 01608	$231.34	

This statement contains the data necessary for completion of your Schedule A (Form 5500) .This is not a representation of the actual Schedule A form. Please contact either a financial advisor or internal Tax Department for assistance.

USAble Life

Statement of Insurance Data for Schedule A (Form 5500)

Name of Plan:	**HOSPICE OF THE GOOD SHEPHERD DBA GOOD SHEPHERD COMMUNITY CARE**		
Name of Insurance Carrier:	**USAble Life**		
Carrier Employer Identification Number (EIN):	**71-0505232**		
NAIC Code:	**94358**		
Contract or Identification Number:	50002092		
Approximate number of persons covered at end of policy or current year:	51		
Policy or Contract Year:	3/1/2024 - 2/28/2025		
Benefit and Contract Type:	Voluntary Group Term Life		
Total Amount of Commissions and Fees Paid:	$2,510.96		
Premiums Paid to Carrier:	$10,043.80		
Premiums Due but Unpaid at End of Year:			
Persons Receiving Commissions:	**Name and Address of the agent, broker, or other person to whom commissions or fees were paid:**	**Total amount of Commissions Paid**	**Total Fees Paid/Additional Compensation**
	INDIGO INSURANCE SERVICES 100 FRONT STREET 20TH FLOOR WORCESTER, MA 01608	$2,510.96	

This statement contains the data necessary for completion of your Schedule A (Form 5500) .This is not a representation of the actual Schedule A form. Please contact either a financial advisor or internal Tax Department for assistance.

USAble Life

Statement of Insurance Data for Schedule A (Form 5500)

Name of Plan:	**HOSPICE OF THE GOOD SHEPHERD DBA GOOD SHEPHERD COMMUNITY CARE**
Name of Insurance Carrier:	**USAble Life**
Carrier Employer Identification Number (EIN):	**71-0505232**
NAIC Code:	**94358**
Contract or Identification Number:	50002092
Approximate number of persons covered at end of policy or current year:	39
Policy or Contract Year:	3/1/2024 - 2/28/2025
Benefit and Contract Type:	Voluntary Long Term Disability
Total Amount of Commissions and Fees Paid:	$4,569.15
Premiums Paid to Carrier:	$18,276.53
Premiums Due but Unpaid at End of Year:	

Persons Receiving Commissions:

Name and Address of the agent, broker, or other person to whom commissions or fees were paid:	Total amount of Commissions Paid	Total Fees Paid/Additional Compensation
INDIGO INSURANCE SERVICES 100 FRONT STREET 20TH FLOOR WORCESTER, MA 01608	$4,569.15	

This statement contains the data necessary for completion of your Schedule A (Form 5500) .This is not a representation of the actual Schedule A form. Please contact either a financial advisor or internal Tax Department for assistance.

USAble Life

Statement of Insurance Data for Schedule A (Form 5500)

Name of Plan:	**HOSPICE OF THE GOOD SHEPHERD DBA GOOD SHEPHERD COMMUNITY CARE**
Name of Insurance Carrier:	**USAble Life**
Carrier Employer Identification Number (EIN):	**71-0505232**
NAIC Code:	**94358**
Contract or Identification Number:	50002092
Approximate number of persons covered at end of policy or current year:	42
Policy or Contract Year:	3/1/2024 - 2/28/2025
Benefit and Contract Type:	Voluntary Short Term Disability
Total Amount of Commissions and Fees Paid:	$1,695.00
Premiums Paid to Carrier:	$6,779.94
Premiums Due but Unpaid at End of Year:	

Persons Receiving Commissions:

Name and Address of the agent, broker, or other person to whom commissions or fees were paid:	Total amount of Commissions Paid	Total Fees Paid/Additional Compensation
INDIGO INSURANCE SERVICES 100 FRONT STREET 20TH FLOOR WORCESTER, MA 01608	$1,695.00	

This statement contains the data necessary for completion of your Schedule A (Form 5500) .This is not a representation of the actual Schedule A form. Please contact either a financial advisor or internal Tax Department for assistance.