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.)
- ☒ 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
GROUP LIFE INSURANCE, WEEKLY INCOME & MEDICAL CARE INSURANCE FOR EMPLOYEES OF LOMANCO

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 10/01/1981

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)
LOMANCO, INC.

PO BOX 519
JACKSONVILLE, AR 72078-0519

2101 W. MAIN STREET
JACKSONVILLE, AR 72076

2b Employer Identification Number (EIN) 41-0839410

2c Plan Sponsor's telephone number 501-982-6511

2d Business code (see instructions) 332110

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.	09/30/2025	TED BELDEN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	09/30/2025	TED BELDEN
	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**	303
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)**	303
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	314
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	314
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	314
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

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
GROUP LIFE INSURANCE, WEEKLY INCOME & MEDICAL CARE INSURANCE FOR EMPLOYEES OF LOMANCO

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
LOMANCO, INC.

D Employer Identification Number (EIN)
41-0839410

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
STANDARD 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
93-0242990	69019	167422	299	04/01/2024	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
8404	

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

DIGITAL INSURANCE LLC
200 GALLERIA PARKWAY
STE 1950
ATLANTA, GA 30339

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
8404			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] 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)**	111706		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	6738		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	3572		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	114872
b Benefit charges (1) Claims paid	**9b(1)**	75000		
(2) Increase (decrease) in claim reserves	**9b(2)**	-33260		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	41740
(4) Claims charged			**9b(4)**	41740
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	8404		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**	0		
(D) Other expenses	**9c(1)(D)**	12058		
(E) Taxes	**9c(1)(E)**	2872		
(F) Charges for risks or other contingencies	**9c(1)(F)**	8083		
(G) Other retention charges	**9c(1)(G)**	41715		
(H) Total retention			**9c(1)(H)**	73132
(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**	
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

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

A Name of plan
GROUP LIFE INSURANCE, WEEKLY INCOME & MEDICAL CARE INSURANCE FOR EMPLOYEES OF LOMANCO

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
LOMANCO, INC.

D Employer Identification Number (EIN)
41-0839410

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
STANDARD 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
93-0242990	69019	167422	94	04/01/2024	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
6426	

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

DIGITAL INSURANCE LLC
200 GALLERIA PARKWAY
STE 1950
ATLANTA, GA 30339

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
6426			3

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

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

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

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

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

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

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

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

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

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	(c) Amount	**(d)** Purpose	

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

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

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** [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** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	49736		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	4964		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	54700
b Benefit charges (1) Claims paid	**9b(1)**	28716		
(2) Increase (decrease) in claim reserves	**9b(2)**	-3893		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	24823
(4) Claims charged			**9b(4)**	24823
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	6426		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**	0		
(D) Other expenses	**9c(1)(D)**	10941		
(E) Taxes	**9c(1)(E)**	1368		
(F) Charges for risks or other contingencies	**9c(1)(F)**	6564		
(G) Other retention charges	**9c(1)(G)**	4578		
(H) Total retention			**9c(1)(H)**	29877
(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**	
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 01/01/2024 and ending 12/31/2024

A Name of plan
GROUP LIFE INSURANCE, WEEKLY INCOME & MEDICAL CARE INSURANCE FOR EMPLOYEES OF LOMANCO

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
LOMANCO, INC.

D Employer Identification Number (EIN)
41-0839410

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
STANDARD 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
93-0242990	69019	167422	126	04/01/2024	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
6795	

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

DIGITAL INSURANCE LLC
200 GALLERIA PARKWAY
STE 1950
ATLANTA, GA 30339

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
6795			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [X] 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)**	84911		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	8672		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	93583
b Benefit charges (1) Claims paid	**9b(1)**	77353		
(2) Increase (decrease) in claim reserves	**9b(2)**	2477		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	79830
(4) Claims charged			**9b(4)**	79830
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	6795		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**	0		
(D) Other expenses	**9c(1)(D)**	26456		
(E) Taxes	**9c(1)(E)**	2340		
(F) Charges for risks or other contingencies	**9c(1)(F)**	3455		
(G) Other retention charges	**9c(1)(G)**	0		
(H) Total retention			**9c(1)(H)**	39046
(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**	
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 01/01/2024 and ending 12/31/2024

A Name of plan
GROUP LIFE INSURANCE, WEEKLY INCOME & MEDICAL CARE INSURANCE FOR EMPLOYEES OF LOMANCO

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
LOMANCO, INC.

D Employer Identification Number (EIN)
41-0839410

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
HUMANA 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
39-1263473	73288	608579	300	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
5521	

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

DIGITAL INSURANCE LLC
200 GALLERIA PARKWAY
STE 1950
ATLANTA, GA 30339

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2743	2778	BONUS	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**	
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** [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)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	49824
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 01/01/2024 and ending 12/31/2024

A Name of plan
GROUP LIFE INSURANCE, WEEKLY INCOME & MEDICAL CARE INSURANCE FOR EMPLOYEES OF LOMANCO

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
LOMANCO, INC.

D Employer Identification Number (EIN)
41-0839410

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
DELTA DENTAL PLAN OF ARKANSAS

(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
71-0561140	47155	000000675	815	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

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

DIGITAL INSURANCE LLC
200 GALLERIA PARKWAY
STE 1950
ATLANTA, GA 30339

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
			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**	
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** [X] 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)**	163269		
(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)**	163269
b Benefit charges (1) Claims paid	**9b(1)**	148239		
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	148239
(4) Claims charged			**9b(4)**	148239
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)**	15030		
(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)**	15030
(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**	
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 01/01/2024 and ending 12/31/2024

A Name of plan
GROUP LIFE INSURANCE, WEEKLY INCOME & MEDICAL CARE INSURANCE FOR EMPLOYEES OF LOMANCO

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
LOMANCO, INC.

D Employer Identification Number (EIN)
41-0839410

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
UNITEDHEALTHCARE 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	0910603	760	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

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** [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** [X] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned (**(1)** + **(2)** - **(3)**)			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add **(1)** and **(2)**)			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	729535
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 C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2024** **This Form is Open to Public Inspection.**

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

A Name of plan
GROUP LIFE INSURANCE, WEEKLY INCOME & MEDICAL CARE INSURANCE FOR EMPLOYEES OF LOMANCO

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
LOMANCO, INC.

D Employer Identification Number (EIN)
41-0839410

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

UNITED HEALTHCARE SERVICES, INC.

41-1289245

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 49	CLAIMS PROCESSOR	367459	Yes [X] No [ ]	Yes [ ] No [X]	0	Yes [X] No [ ]

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

DIGITAL INSURANCE LLC

200 GALLERIA PKWY SE STE 1950
ATLANTA, GA 30339-5946

58-2522668

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
55	BROKER	66192	Yes [ ] No [X]	Yes [ ] No [X]	0	Yes [ ] No [X]

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

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

Part I Service Provider Information (continued)

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

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

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

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

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

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

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

Part II	Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

PLAN INFORMATION REPORT FOR THE PERIOD OF 4/1/2024 TO 2/28/2025

LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION

IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500

IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: LOMANCO INC

PART I

1) COVERAGE - LIFE INSURANCE

a) CARRIER:	Standard Insurance Company
b) EIN:	93-0242990
c) NAIC CODE:	000-69019
d) CONTRACT NUMBER:	167422
e) NUMBER OF PERSONS COVERED:	299
f) FROM:	4/1/2024
g) TO:	2/28/2025

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID:	$8,403.88
FEED PAID / AMOUNT:	$0.00

A) NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID	B) AMOUNT OF COMMISSION PAID		FEES PAID		E) ORG. CODE
	COMMISSIONS	CONTINGENT COMP*	C) AMOUNT	D) PURPOSE	
DIGITAL INSURANCE LLC 200 GALLERIA PARKWAY STE 1950 ATLANTA, GA 30339	$4,148.50	$4,255.38	$0.00		3

TOTAL COMMISSIONS PAID	$4,148.50
TOTAL CONTINGENT COMP PAID	$4,255.38

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

LONG FORM INFORMATION

PART III - 167422

7) BENEFIT TYPE: LIFE INSURANCE

EXPERIENCE RATED CONTRATS

a) PREMIUMS: (1) AMOUNT RECEIVED:	$111,705.72	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID:	$6,738.00	
(3) INCREASE (DECREASE) IN UNEARED PREMIUM RESERVE:	$3,572.00	
(4) EARNED PREMIUM ((1)+(2) - (3)):		$114,871.72
b) BENEFIT CHARGES: (1) CLAIMS PAID:	$75,000.00	
(2) INCREASE (DECREASE) CLAIM RESERVES:	($33,260.00)	
(3) INCURRED CLAIMS ((1)+(2)):		$41,740.00
(4) CLAIMS CHARGED:		$41,740.00
c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:		
(A) COMMISSIONS:	$8,403.88	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES:	$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS:	$0.00	
(D) OTHER EXPENSES:	$12,058.27	
(E) TAXES:	$2,871.80	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES:	$8,083.35	
(G) OTHER RETENTION CHARGES:	$41,714.69	
(H) TOTAL RETENTION:		$73,132.00
ci) DIVIDEND OR RETROACTIVE RATE REFUND:		
d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR		
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT		$ 0.00
(2) CLAIM RESERVES:		$0.00
(3) OTHER RESERVES:		$0.00
di) DIVIDENTS OR RETROACTIVE RAE REFUNDS DUE:		$0.00

Standard Insurance Company HEREBY CERTIFIES THAT THIS INFORMATION IS COMPLETE AND ACCURATE

PLAN INFORMATION REPORT FOR THE PERIOD OF 4/1/2024 TO 2/28/2025

LONG FORM INFORMATION

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IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: LOMANCO INC

PART I

1) COVERAGE - LONG TERM DISABILITY

a) CARRIER:	Standard Insurance Company
b) EIN:	93-0242990
c) NAIC CODE:	000-69019
d) CONTRACT NUMBER:	167422
e) NUMBER OF PERSONS COVERED:	94
f) FROM:	4/1/2024
g) TO:	2/28/2025

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID:	$6,425.80
FEED PAID / AMOUNT:	$0.00

A) NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID	B) AMOUNT OF COMMISSION PAID		FEES PAID		E) ORG. CODE
	COMMISSIONS	CONTINGENT COMP*	C) AMOUNT	D) PURPOSE	
DIGITAL INSURANCE LLC 200 GALLERIA PARKWAY STE 1950 ATLANTA, GA 30339	$4,486.80	$1,939.00	$0.00		3

TOTAL COMMISSIONS PAID	$4,486.80
TOTAL CONTINGENT COMP PAID	$1,939.00

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

LONG FORM INFORMATION

PART III - 167422

7) BENEFIT TYPE: LONG TERM DISABILITY

EXPERIENCE RATED CONTRATS

a) PREMIUMS: (1) AMOUNT RECEIVED:	$49,736.05	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID:	$4,964.00	
(3) INCREASE (DECREASE) IN UNEARED PREMIUM RESERVE:	$0.00	
(4) EARNED PREMIUM ((1)+(2) - (3)):		$54,700.05
b) BENEFIT CHARGES: (1) CLAIMS PAID:	$28,716.27	
(2) INCREASE (DECREASE) CLAIM RESERVES:	($3,893.06)	
(3) INCURRED CLAIMS ((1)+(2)):		$24,823.21
(4) CLAIMS CHARGED:		$24,823.21
c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:		
(A) COMMISSIONS:	$6,425.80	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES:	$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS:	$0.00	
(D) OTHER EXPENSES:	$10,941.43	
(E) TAXES:	$1,367.50	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES:	$6,564.00	
(G) OTHER RETENTION CHARGES:	$4,578.06	
(H) TOTAL RETENTION:		$29,876.79
ci) DIVIDEND OR RETROACTIVE RATE REFUND:		
d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR		
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT		$ 0.00
(2) CLAIM RESERVES:		$0.00
(3) OTHER RESERVES:		$0.00
di) DIVIDENTS OR RETROACTIVE RAE REFUNDS DUE:		$0.00

Standard Insurance Company HEREBY CERTIFIES THAT THIS INFORMATION IS COMPLETE AND ACCURATE

PLAN INFORMATION REPORT FOR THE PERIOD OF 4/1/2024 TO 2/28/2025

LONG FORM INFORMATION

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IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: LOMANCO INC

PART I

1) COVERAGE - TEMPORARY DISABILITY

a) CARRIER:	Standard Insurance Company
b) EIN:	93-0242990
c) NAIC CODE:	000-69019
d) CONTRACT NUMBER:	167422
e) NUMBER OF PERSONS COVERED:	126
f) FROM:	4/1/2024
g) TO:	2/28/2025

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID:	$6,795.05
FEED PAID / AMOUNT:	$0.00

A) NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID	B) AMOUNT OF COMMISSION PAID		FEES PAID		E) ORG. CODE
	COMMISSIONS	CONTINGENT COMP*	C) AMOUNT	D) PURPOSE	
DIGITAL INSURANCE LLC 200 GALLERIA PARKWAY STE 1950 ATLANTA, GA 30339	$3,698.21	$3,096.84	$0.00		3

TOTAL COMMISSIONS PAID	$3,698.21
TOTAL CONTINGENT COMP PAID	$3,096.84

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

LONG FORM INFORMATION

PART III - 167422

7) BENEFIT TYPE: TEMPORARY DISABILITY

EXPERIENCE RATED CONTRATS

a) PREMIUMS: (1) AMOUNT RECEIVED:	$84,910.53	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID:	$8,672.00	
(3) INCREASE (DECREASE) IN UNEARED PREMIUM RESERVE:	$0.00	
(4) EARNED PREMIUM ((1)+(2) - (3)):		$93,582.53
b) BENEFIT CHARGES: (1) CLAIMS PAID:	$77,352.82	
(2) INCREASE (DECREASE) CLAIM RESERVES:	$2,477.00	
(3) INCURRED CLAIMS ((1)+(2)):		$79,829.82
(4) CLAIMS CHARGED:		$79,829.82
c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:		
(A) COMMISSIONS:	$6,795.05	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES:	$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS:	$0.00	
(D) OTHER EXPENSES:	$26,456.28	
(E) TAXES:	$2,339.58	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES:	$3,455.16	
(G) OTHER RETENTION CHARGES:	$0.00	
(H) TOTAL RETENTION:		$39,046.07
ci) DIVIDEND OR RETROACTIVE RATE REFUND:		
d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR		
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT		$ 0.00
(2) CLAIM RESERVES:		$0.00
(3) OTHER RESERVES:		$0.00
di) DIVIDENTS OR RETROACTIVE RAE REFUNDS DUE:		$0.00

Standard Insurance Company HEREBY CERTIFIES THAT THIS INFORMATION IS COMPLETE AND ACCURATE

Humana

This information is for use in preparing the Schedule A or C, Insurance Information (Form 5500). If you have any questions regarding this information, please email 5500@humana.com or call 1-800-558-4444, extension 3375713.

NOTICE: The below information is provided from the ordinary business records of Humana Inc. to assist the Plan Administrator in complying with certain plan reporting requirements - Schedule A or C of Form(s) 5500. Humana Inc. certifies that this information is accurate and complete to the best of its knowledge and belief.
Commissions paid on your plan(s) from the commission component of your premium
Bonuses paid prorated by the proportion of the agent's eligible volume that is represented by your plan(s) and do not change your premium or fees
Non-Monetary Compensation, prorated by the proportion of the agent's eligible non-monetary compensation represented by your plan(s)
The amount of Premium and Administrative Fees are based on the payments made during the reporting period.
The Subscriber Counts are based on the last day of the contract and are not restated based on retro changes of membership.

LOMANCO
2101 W MAIN ST
JACKSONVILLE, AR 72076-4205

Enterprise Number: 608579

Reporting Period:

3/1/2024 To 2/28/2025

Group Number	Product Line	Product Description	NAIC Company Code	Insurance Tax ID	Insurance Name
608579	VISION	Vision Commercial Non-Surg	73288	39-1263473	Humana Insurance Company

Fully Insured

Group Number	Product Line	Product Description	Subscriber Count	Premium / Admin Fee	Commissions	Bonuses	Non-Monetary
608579	VISION	Vision Commercial Non-Surg	300	49,824.20	2,742.82	2,777.97	0.00
				$49,824.20	**$2,742.82**	**$2,777.97**	**$0.00**

Fully Insured

Commission Type	Agent Number	Agent Name & Address	Group Number	Product Line	Product Description	Commission Paid
Bonus	1281744	DIGITAL INSURANCE INC-GA 200 GALLERIA PARKWAY STE 1950 ATLANTA, GA 30339-5946	608579	VISION	Vision Commercial Non-Surg	2,777.97
Commission	1281744	DIGITAL INSURANCE INC-GA 200 GALLERIA PARKWAY STE 1950 ATLANTA, GA 30339-5946	608579	VISION	Vision Commercial Non-Surg	2,742.82
						$5,520.79

DELTA DENTAL

Schedule C (Form 5500)
Insurance Information

Delta Dental of Arkansas
1513 Country Club Road
Sherwood, AR 72120
(501) 835-3400 (800) 462-5410

The following information is provided in accordance with ERISA section 103(a)(2).

FORM 5500:

Line 7. Number of employees at end of year: **301**
Number of enrollees (including dependents) at end of year: **815**

SCHEDULE C (Form 5500)
INSURANCE INFORMATION

For calendar plan year or fiscal plan year beginning **03/01/2024** and ending **02/28/2025**.

A. Name of Plan: *Prepaid Dental Care Plan*
B. Plan Number: *(Use the plan number your company has selected)*
C. Plan sponsor's Name: **LOMANCO, INC.**
D. Employer ID Number: *(Use your company's EIN)*

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

1. Coverage
   (a) Insurance carrier: **Delta Dental Plan of Arkansas**
   (b) EIN: **710561140**
   (c) NAIC: **47155**

   (d) Contract or identification number: **000000675**
   (e) Approximate number of persons covered at end of policy or contract year: **815**

   Policy or contract year: (f) From: **03/01/2024** (g) To: **02/28/2025**

2. Insurance fees and commissions paid to agents, brokers, and other persons:
   Total amount of commissions paid: **$0.00**
   (e) Organization Code **3**

   Name and addresses of the agents, brokers, or other persons to whom commission or fees were paid:

   (a) Name and address of the agent, broker, or other person:
   DIGITAL INSURANCE INC.
   200 GALLERIA PKWY SE STE 1950
   ATLANTA, GA 30339
   (b) Amount of commissions paid: **$0.00**

Part II: Insured Pension Plans

Not Applicable

DELTA DENTAL

Schedule C (Form 5500)
Insurance Information

Delta Dental of Arkansas
1513 Country Club Road
Sherwood, AR 72120
(501) 835-3400 (800) 462-5410

The following information is provided in accordance with ERISA section 103(a)(2).

Part III: Welfare Benefit Contract Information

7. Benefit and contract type
   (b) **Dental**

8. Experience-rated contracts

a. Premiums		
(i) Amount Received	163,269	
(ii) Increase (decrease) in amount due but unpaid	0	
(iii) Increase (decrease) in unearned premium reserve	0	
(iv) Earned ((1) + (2) - (3))		163,269
b. Benefit charges		
(i) Claims paid	148,239	
(ii) Increase (decrease) in claims reserves	0	
(iii) Incurred claims (add (1) and (2))	148,239	
(iv) Claims charged:		148,239
c. Remainder of premium		
(i) Retention Charges (on an accrual basis)		
(A) Commissions	0	
(B) Administrative service or other fees	15,030	
(C) Other specific acquisition costs	0	
(D) Other expenses	0	
(E) Taxes	0	
(F) Charges for risks or other contingencies	0	
(G) Other retention charges	0	
(H) Total Retention		15,030
(ii) Dividends or retroactive rate refunds		0
d. Status of policyholder reserves at end of year		
(i) Amount held to provide benefits after retirement		0
(ii) Claim reserves		0
(iii)Other reserves		0

9. Nonexperience-rated contracts

a. Total premiums or subscription charges paid to carrier	0
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, item 2 above, report amount	0

INSURANCE INFORMATION - WELFARE PLAN
DEPARTMENT OF LABOR FORM 5500
SCHEDULE A-PARTS I AND III
INFORMATION CERTIFIED BY CARRIER

GROUP INSURANCE PLAN OF
Lomanco, Inc.

PRINCIPAL ADDRESS

For Policy Year Beginning March 1, 2024 And Ending February 28, 2025

1. Coverage Information:

(a) Name of Insurance carrier UnitedHealthcare 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	0910603	760	03/01/24	02/28/25

3. Persons receiving commissions and fees. [1]

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organizational Code
None	None	None	N/A	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organizational Code
None	None	None	N/A	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organizational Code
None	None	None	N/A	3

8. Benefit and contract type [2]	List gross premium for each benefit and contract type	Premium rate or subscription charge
Stop Loss	$729,535	Rates have been established in accordance with our customary rate review practices which take into consideration all risks in this category.

10. Non experienced rated contracts:

(a) Total premium or subscription charges paid to carrier $729,535

(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 3 above, report amount

specify nature of costs → .... NONE

The above information is hereby certified to be complete and accurate according to the Carrier's records.

George Marques
(Underwriting Signature)

Dated: 9/12/2025

1. This information furnished to the Policyholder for completion of item 3 of part I, Schedule A, of Form 5500. These are commissions charged to the policy for the policy year, but not necessarily those paid during that period.
2. These employer contracts with premiums paid exclusively out of the employer's general assests without any employee contributions generally are not paln assests and are not reportable on Schedule A.

Ref # 5500-02

DATA FOR PLANS FOR WHICH BENEFITS ARE PROVIDED ON OTHER THAN AN INSURED BASIS

The information set forth below is furnished to the Contractholder to assist in the completion of U. S. Department of Labor Annual Return/Report Form 5500

Name of Contractholder: Lomanco, Inc.

Contract Number: 910603

Data for Period Beginning: March 1, 2024 and Ending: February 28, 2025

Form 5500 Schedule C Part 1, Line 2 Information on Service Providers Receiving Direct or Indirect Compensation

2(a) United Healthcare Services, Inc. EIN: 41-1289245

(b) Service codes	(c) Relationship to employer	(d) Direct compensation paid by the plan	(e) Was any indirect Compensation received	(f) Did indirect compensation include eligible indirect compensation	(g) Enter total indirect compensation excluding 2 (f)	(h) Is a formula being provided in lieu of/in addition to 2 (g)
12, 49	Claims Processor	$367,459	x Yes ___ No	___ Yes x No	$0	x Yes ___ No Refer to Footnotes

2(a) DIGITAL INSURANCE LLC
200 GALLERIA PKWY SE STE 1950
ATLANTA, GA 303395946 EIN: 58-2522668

(b) Service codes	(c) Relationship to employer	(d) Direct compensation paid by the plan	(e) Was any indirect Compensation received	(f) Did indirect compensation include eligible indirect compensation	(g) Enter total indirect compensation excluding 2 (f)	(h) Is a formula being provided in lieu of/in addition to 2 (g)
55	Broker	$66,192	___ Yes x No	___ Yes x No	$0	___ Yes x No

2(a)

(b) Service codes	(c) Relationship to employer	(d) Direct compensation paid by the plan	(e) Was any indirect Compensation received	(f) Did indirect compensation include eligible indirect compensation	(g) Enter total indirect compensation excluding 2 (f)	(h) Is a formula being provided in lieu of/in addition to 2 (g)
			___ Yes ___ No	___ Yes ___ No		___ Yes ___ No

2(a)

(b) Service codes	(c) Relationship to employer	(d) Direct compensation paid by the plan	(e) Was any indirect Compensation received	(f) Did indirect compensation include eligible indirect compensation	(g) Enter total indirect compensation excluding 2 (f)	(h) Is a formula being provided in lieu of/in addition to 2 (g)
			___ Yes ___ No	___ Yes ___ No		___ Yes ___ No

Footnotes - 2(h) Formula

Consistent with and as described in the administrative services agreement (ASA) between Lomanco, Inc. and United Healthcare Services, Inc. (UnitedHealthcare), and in addition to direct compensation that the Plan may pay UnitedHealthcare for prescription drugs and prescription drug services, UnitedHealthcare has received certain indirect compensation for its pharmacy management services related to the plan as follows:

• Manufacturer rebate amounts retained by UnitedHealthcare. These actual rebates from manufacturers can vary depending on benefit design and other factors, and most often range from $1.35 to $2.35 PMPM for prescription drug products dispensed under the Plan's medical benefit.