

<p style="text-align: center;"><b>Form 5500</b></p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p><b>Annual Return/Report of Employee Benefit Plan</b></p> <p style="font-size: x-small;">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).</p> <p>▶ <b>Complete all entries in accordance with the instructions to the Form 5500.</b></p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; font-weight: bold;">2024</p> <hr/> <p style="font-weight: bold;">This Form is Open to Public Inspection</p>
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**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**

<p><b>1a</b> Name of plan  <u>EATON ELECTRICAL DE PUERTO RICO MEDICAL, DENTAL &amp; LIFE INSURANCE PLAN</u></p>	<p><b>1b</b> Three-digit plan number (PN) ▶ <u>501</u></p>
<p><b>2a</b> 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)  <u>EATON INTELLIGENT POWER LIMITED</u></p> <p><u>EATON CORPORATION PLC</u>  <u>601 TRAVIS STREET SUITE 1850</u>  <u>HOUSTON, TX 77002-1372</u></p>	<p><b>1c</b> Effective date of plan  <u>02/01/1994</u></p> <p><b>2b</b> Employer Identification Number (EIN)  <u>98-1098668</u></p> <p><b>2c</b> Plan Sponsor's telephone number  <u>787-656-7791</u></p> <p><b>2d</b> Business code (see instructions)  <u>335900</u></p>

**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.

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	10/03/2025	JACK LIU
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	10/03/2025	JACK LIU
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE



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

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

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

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

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

Receipt Confirmation Code \_\_\_\_\_

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<p style="text-align: center;"><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: 24pt;"><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

<p><b>A</b> Name of plan <span style="color: blue;">EATON ELECTRICAL DE PUERTO RICO MEDICAL, DENTAL &amp; LIFE INSURANCE PLAN</span></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><span style="color: blue;">501</span></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <span style="color: blue;">EATON INTELLIGENT POWER LIMITED</span></p>	<p><b>D</b> Employer Identification Number (EIN) <span style="color: blue;">98-1098668</span></p>	

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1 Coverage Information:**

**(a)** Name of insurance carrier  
TRIPLE S SALUD, 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	(g) To
66-0555677	55816	SP0004000	1577	01/01/2024	12/31/2024

**2 Insurance fee and commission information.** Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

<p><b>(a)</b> Total amount of commissions paid</p> <p style="color: blue;">81884</p>	<p><b>(b)</b> Total amount of fees paid</p> <p style="color: blue;">0</p>
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**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

CGF INSURANCE LLC 22 CALLE GONZALEZ GIUSTI SUITE 200  
GUAYNABO, PR 00968

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
81884			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	

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

**c** Premiums due but unpaid at the end of the year ..... **6c**

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... **6d**  
 Specify nature of costs ▶

**e** Type of contract: (1)  individual policies (2)  group deferred annuity  
 (3)  other (specify) ▶

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

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

- a** Type of contract: (1)  deposit administration (2)  immediate participation guarantee  
 (3)  guaranteed investment (4)  other ▶

<b>b</b> Balance at the end of the previous year .....			<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>			
	<b>7c(2)</b>			
	<b>7c(3)</b>			
	<b>7c(4)</b>			
	<b>7c(5)</b>			
	(6) Total additions .....			
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....			<b>7d</b>	
<b>e</b> Deductions:				
	<b>7e(1)</b>			
	<b>7e(2)</b>			
	<b>7e(3)</b>			
	<b>7e(4)</b>			
(5) Total deductions .....		<b>7e(5)</b>	0	
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....			<b>7f</b>	

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

**8** Benefit and contract type (check all applicable boxes)

- a**  Health (other than dental or vision)     
 **b**  Dental     
 **c**  Vision     
 **d**  Life insurance  
**e**  Temporary disability (accident and sickness)     
 **f**  Long-term disability     
 **g**  Supplemental unemployment     
 **h**  Prescription drug  
**i**  Stop loss (large deductible)     
 **j**  HMO contract     
 **k**  PPO contract     
 **l**  Indemnity contract  
**m**  Other (specify) ▶ **ORGAN AND TISSUE TRANSPLANT**

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	176298
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? .....  Yes  No

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

**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**

<b>A</b> Name of plan <b>EATON ELECTRICAL DE PUERTO RICO MEDICAL, DENTAL &amp; LIFE INSURANCE PLAN</b>		<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>EATON INTELLIGENT POWER LIMITED</b>		<b>D</b> Employer Identification Number (EIN) <b>98-1098668</b>

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**EYEMED VISION CARE / FIDELITY SECURITY LIFE INSURANCE COMPANY**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>43-0949844</b>	<b>71870</b>	<b>96634771001</b>	<b>2068</b>	<b>01/01/2024</b>	<b>12/31/2024</b>

**2 Insurance fee and commission information.** Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

<b>(a)</b> Total amount of commissions paid <b>0</b>	<b>(b)</b> Total amount of fees paid <b>0</b>
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**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>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

**c** Premiums due but unpaid at the end of the year ..... **6c**

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... **6d**  
 Specify nature of costs ▶

**e** Type of contract: (1)  individual policies (2)  group deferred annuity  
 (3)  other (specify) ▶

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

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

**a** Type of contract: (1)  deposit administration (2)  immediate participation guarantee  
 (3)  guaranteed investment (4)  other ▶

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
	(6) Total additions .....	<b>7c(6)</b>
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	
<b>e</b> Deductions:		
	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
(5) Total deductions .....	<b>7e(5)</b>	0
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....	<b>7f</b>	

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

**8** Benefit and contract type (check all applicable boxes)

- a**  Health (other than dental or vision)
- b**  Dental
- c**  Vision
- d**  Life insurance
- e**  Temporary disability (accident and sickness)
- f**  Long-term disability
- g**  Supplemental unemployment
- h**  Prescription drug
- i**  Stop loss (large deductible)
- j**  HMO contract
- k**  PPO contract
- l**  Indemnity contract
- m**  Other (specify) ▶

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	66090
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? .....  Yes  No

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

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p><b>A</b> Name of plan <b>EATON ELECTRICAL DE PUERTO RICO MEDICAL, DENTAL &amp; LIFE INSURANCE PLAN</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>EATON INTELLIGENT POWER LIMITED</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>98-1098668</b></p>	

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**TRIPLE S SALUD, 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	(g) To
66-0555677	55816	SP0004000RET	11	01/01/2024	12/31/2024

**2 Insurance fee and commission information.** Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

<p><b>(a)</b> Total amount of commissions paid</p> <p style="text-align: center;"><b>801</b></p>	<p><b>(b)</b> Total amount of fees paid</p> <p style="text-align: center;"><b>0</b></p>
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**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

**CGF INSURANCE LLC** **22 CALLE GONZALEZ GIUSTI SUITE 200**  
**GUAYNABO, PR 00968**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
801			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
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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	

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

**c** Premiums due but unpaid at the end of the year ..... **6c**

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... **6d**  
 Specify nature of costs ▶

**e** Type of contract: (1)  individual policies (2)  group deferred annuity  
 (3)  other (specify) ▶

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

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

- a** Type of contract: (1)  deposit administration (2)  immediate participation guarantee  
 (3)  guaranteed investment (4)  other ▶

<b>b</b> Balance at the end of the previous year .....			<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>			
	<b>7c(2)</b>			
	<b>7c(3)</b>			
	<b>7c(4)</b>			
	<b>7c(5)</b>			
	(6) Total additions .....			
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....			<b>7d</b>	
<b>e</b> Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	<b>7e(1)</b>		
	(2) Administration charge made by carrier.....	<b>7e(2)</b>		
	(3) Transferred to separate account .....	<b>7e(3)</b>		
	(4) Other (specify below) .....	<b>7e(4)</b>		
(5) Total deductions .....		<b>7e(5)</b>	0	
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....			<b>7f</b>	

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

**8** Benefit and contract type (check all applicable boxes)

- a**  Health (other than dental or vision)     
 **b**  Dental     
 **c**  Vision     
 **d**  Life insurance  
**e**  Temporary disability (accident and sickness)     
 **f**  Long-term disability     
 **g**  Supplemental unemployment     
 **h**  Prescription drug  
**i**  Stop loss (large deductible)     
 **j**  HMO contract     
 **k**  PPO contract     
 **l**  Indemnity contract  
**m**  Other (specify) ▶ **ORGAN AND TISSUE TRANSPLANT**

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	1415
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? .....  Yes  No

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

**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**

<b>A</b> Name of plan <b>EATON ELECTRICAL DE PUERTO RICO MEDICAL, DENTAL &amp; LIFE INSURANCE PLAN</b>		<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>EATON INTELLIGENT POWER LIMITED</b>		<b>D</b> Employer Identification Number (EIN) <b>98-1098668</b>

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1 Coverage Information:**

**(a)** Name of insurance carrier

**TRIPLE-S VIDA, INC.**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
66-0258488	73814	V2101001	1535	01/01/2024	12/31/2024

**2 Insurance fee and commission information.** Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

<b>(a)</b> Total amount of commissions paid <b>61125</b>	<b>(b)</b> Total amount of fees paid <b>0</b>
---	--

**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

**POPULAR RISK SERVICES LLC**  
**PO BOX 71390**  
**SAN JUAN, PR 00936-8390**

<b>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	
<b>61125</b>			<b>3</b>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

**c** Premiums due but unpaid at the end of the year ..... **6c**

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... **6d**  
 Specify nature of costs ▶

**e** Type of contract: (1)  individual policies (2)  group deferred annuity  
 (3)  other (specify) ▶

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

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

**a** Type of contract: (1)  deposit administration (2)  immediate participation guarantee  
 (3)  guaranteed investment (4)  other ▶

<b>b</b> Balance at the end of the previous year .....			<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>			
	<b>7c(2)</b>			
	<b>7c(3)</b>			
	<b>7c(4)</b>			
	<b>7c(5)</b>			
	(6) Total additions .....			
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....			<b>7d</b>	
<b>e</b> Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	<b>7e(1)</b>		
	(2) Administration charge made by carrier.....	<b>7e(2)</b>		
	(3) Transferred to separate account .....	<b>7e(3)</b>		
	(4) Other (specify below) .....	<b>7e(4)</b>		
(5) Total deductions .....		<b>7e(5)</b>	0	
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....			<b>7f</b>	

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

**8** Benefit and contract type (check all applicable boxes)

- a**  Health (other than dental or vision)     
 **b**  Dental     
 **c**  Vision     
 **d**  Life insurance  
**e**  Temporary disability (accident and sickness)     
 **f**  Long-term disability     
 **g**  Supplemental unemployment     
 **h**  Prescription drug  
**i**  Stop loss (large deductible)     
 **j**  HMO contract     
 **k**  PPO contract     
 **l**  Indemnity contract  
**m**  Other (specify) ▶

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	509379
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? .....  Yes  No

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

**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**

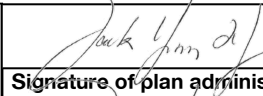
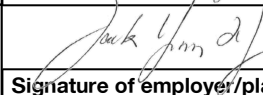
- A** This return/report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- B** This return/report is:  a single-employer plan  a DFE (specify) \_\_\_\_\_  
 the first return/report  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

<b>1a</b> Name of plan EATON ELECTRICAL DE PUERTO RICO MEDICAL, DENTAL & LIFE INSURANCE PLAN		<b>1b</b> Three-digit plan number (PN) ▶	501
		<b>1c</b> Effective date of plan	02/01/1994
<b>2a</b> 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) EATON INTELLIGENT POWER LIMITED  EATON CORPORATION PLC 601 TRAVIS STREET SUITE 1850  HOUSTON TX 77002-1372		<b>2b</b> Employer Identification Number (EIN)	98-1098668
		<b>2c</b> Plan Sponsor's telephone number	787-656-7791
		<b>2d</b> Business code (see instructions)	335900

**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.

<b>SIGN HERE</b>		10/3/25	JACK LIU
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>		10/3/25	JACK LIU
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2024)  
v. 240311

<b>3a</b> Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor EATON CORPORATION H & W ADMINISTRATIVE COMMITTEE EATON CORPORATION 1000 EATON BOULEVARD CLEVELAND OH 44122	<b>3b</b> Administrator's EIN 34-0196300 <hr/> <b>3c</b> Administrator's telephone number 440-523-5000
---	---

<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN
--	-----------------------------------

<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	1,683
<b>6</b> 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).		
<b>a (1)</b> Total number of active participants at the beginning of the plan year .....	<b>6a(1)</b>	1,586
<b>a (2)</b> Total number of active participants at the end of the plan year .....	<b>6a(2)</b>	1,648
<b>b</b> Retired or separated participants receiving benefits .....	<b>6b</b>	90
<b>c</b> Other retired or separated participants entitled to future benefits .....	<b>6c</b>	
<b>d</b> Subtotal. Add lines 6a(2), 6b, and 6c .....	<b>6d</b>	1,738
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....	<b>6e</b>	
<b>f</b> Total. Add lines 6d and 6e .....	<b>6f</b>	
<b>g (1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....	<b>6g(1)</b>	
<b>(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....	<b>6g(2)</b>	
<b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .....	<b>6h</b>	
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	

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

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  
 4A 4B 4D 4E 4Q

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

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

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

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