

<p style="text-align: center;">Form 5500</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>Annual Return/Report of Employee Benefit Plan</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 style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; text-align: center;">2024</p> <hr/> <p style="text-align: center;">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 04/01/2024 and ending 03/31/2025

A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)

a single-employer plan a DFE (specify) _____

B This return/report is: the first return/report the final return/report

an amended return/report a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here.

D Check box if filing under: Form 5558 automatic extension the DFVC program

special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here.

Part II Basic Plan Information—enter all requested information

<p>1a Name of plan <u>UNITED LIQUID WASTE RECYCLING, INC EMPLOYEE BENEFITS PLANS</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>503</u></p>
<p>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) <u>UNITED LIQUID WASTE RECYCLING, INC</u></p> <p><u>PO BOX 247</u> <u>715 MORGAN ST</u> <u>CLYMAN, WI 53016-0247</u> <u>CLYMAN, WI 53016</u></p>	<p>1c Effective date of plan <u>04/01/2024</u></p> <p>2b Employer Identification Number (EIN) <u>39-1970650</u></p> <p>2c Plan Sponsor's telephone number <u>920-696-3248</u></p> <p>2d Business code (see instructions) <u>221300</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.

SIGN HERE	Filed with authorized/valid electronic signature.	10/17/2025	MAGGIE REED
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	111
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	111
	6a(2)	115
	6b	0
	6c	0
	6d	115
	6e	
	6f	115
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

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

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

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **04/01/2024** and ending **03/31/2025**

<p>A Name of plan UNITED LIQUID WASTE RECYCLING, INC EMPLOYEE BENEFITS PLANS</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>503</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 UNITED LIQUID WASTE RECYCLING, INC</p>	<p>D Employer Identification Number (EIN) 39-1970650</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
PRINCIPAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
42-0127290	61271	10771155	158	04/01/2024	03/31/2025

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.

<p>(a) Total amount of commissions paid 4344</p>	<p>(b) Total amount of fees paid 2330</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
DBA TERRILL INSURANCE **900 N SHORE DR STE 22**
LAKE BLUFF, IL 60044

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2330	BONUS		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
HEMB INSURANCE GROUP LLC **2801 COHO ST. STE 200**
MADISON, WI 53713-4531

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3057			3

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

WISCONSIN ILLINOIS UBA LLC

2801 COHO ST STE 200
MADISON, WI 53713-4531

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1287			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	

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	
(2) Increase (decrease) in amount due but unpaid	9a(2)	
(3) Increase (decrease) in unearned premium reserve	9a(3)	
(4) Earned ((1) + (2) - (3))		9a(4)
b Benefit charges (1) Claims paid	9b(1)	
(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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)
(2) Claim reserves		9d(2)
(3) Other reserves		9d(3)
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	66152
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

Lynda Rieks
Ops Support Analyst
rieks.lynda@principal.com

Workplace Benefits Solutions
Principal Life Insurance Company
711 High Street
Des Moines, IA 50392-5120



May 9, 2025

UNITED LIQUID WASTE RECYCLING
LINDA MUELLER
PO BOX 247
CLYMAN WI 53016

HEMB INSURANCE
2801 COHO ST STE 200
MADISON WI 53713-4531

Re Acct No. 1077155

Anniversary Date: April 1, 2025

We thank you for selecting Principal for your insurance needs.

As you are likely aware, most insured welfare benefit plans that are subject to the Employee Retirement Income Security Act (ERISA), and that cover 100 or more employee plan participants at the beginning of their plan year, are required to file Form 5500 with the Employee Benefits Security Administration of the U.S. Department of Labor. The Schedule A must be attached to the Form 5500 filing if any of the benefits under the plan are provided by an insurance company.

We've enclosed your Schedule A Insurance Information **worksheet** for the period April 1, 2024 through March 31, 2025 to assist you with your filing of the Schedule A (Form 5500). The paid premium reported on the Schedule A worksheet represents premium received and applied to your account during the reported period. This information will need to be transferred to a Schedule A template.

If you have questions about the applicability of these requirements to your plan, please consult with your legal or tax advisor. For filing assistance and additional information:

Contact the Employee Benefits Security Administration, an agency within the U.S. Department of Labor, at 1-866-444-3272 or www.dol.gov/ebsa.

The Department of Labor requires filings to be submitted electronically at www.efast.dol.gov.

Additional help with EFAST can be obtained by calling 1-866-GO-EFAST (1-866-463-3278).

A copy of the enclosed Schedule A Insurance Information worksheet will also be available online through the Employer Web link at www.principal.com. For assistance with enrolling in the Employer Web Service, policyholders can call the Principal's Employer Group Plan Customer Service at 1-800-843-1371. Brokers, please contact our Advisor Web Support Team at 1-800-554-3395.

If you have questions about the enclosed information, please contact me at the email address at the top of this letter.

Enclosure

Contract # 1077155
Name of Plan UNITED LIQUID WASTE RECYCING
Data Period April 1, 2024 to March 31, 2025



**Principal Life Insurance Company
Schedule A (Form 5500) Worksheet**

Section 1: Coverage

(a) Name of Insurance Carrier Principal Life Insurance Company		(b) EIN 42-0127290	(c) NAIC Code 61271	
(d) Contract or Id Number	1077155	Approx. no. of Persons cov. At End of Policy Year	Total (e)	158
Combined Numbers			Employees	118
			Dependents	40
Policy or Contract Year From (f) April 1, 2024 To (g) March 31, 2025				

Section 2: Insurance fee and commissions information

	(a) Commissions Paid	(b) Fees Paid
Total (from below)	4,344	2,330

Section 3: Persons receiving commissions and fees

(a) Name & Address of Agents or Brokers to whom Commissions or Fees Paid	(b) Amount of Commissions Paid	Fees Paid (c) Amount / (d) Purpose	(e) Org Code
WISCONSIN ILLINOIS UBA LLC DBA HEMB INSURANCE 2801 COHO ST STE 200 MADISON WI 53713-4531	1,287		3 - Ins Agent or Broker
HEMB INSURANCE GROUP LLC 2801 COHO ST STE 200 MADISON WI 53713-4531	3,057		3 - Ins Agent or Broker
WISCONSIN ILLINOIS UBA LLC DBA TERRILL INSURANCE 900 N SHORE DR STE 22 LAKE BLUFF IL 60044		2,330 * Bonus	3 - Ins Agent or Broker

Reportable commissions and fees include all forms of compensation directly or indirectly attributable to your Principal Life Insurance Company policies.

* This part of the compensation amount reflects a portion of administrative expenses that are allocated across all policies sold by PLIC. It is not part of your actual cost.

Section 8: Benefit and Contract Type

(a) Health <small>(other than dental or vision)</small>	(b) <input checked="" type="checkbox"/> Dental	(c) <input checked="" type="checkbox"/> Vision	(d) Life Ins.
(e) <input checked="" type="checkbox"/> Temporary Disability <small>(accident and sickness)</small>	(f) Long Term Disability	(g) Supplemental Unemployment	(h) Prescription Drug
(i) Stop Loss <small>(large deductible)</small>	(j) HMO Contract	(k) <input checked="" type="checkbox"/> PPO Contract	(l) Indemnity Contract
(m) Other: _____			

If applicable, the Schedule A worksheet includes voluntary products. If applicable, Basic Life and VTL coverages included AD&D.

Section 10: Non-Experience Rated Contracts

(a) Total Premiums Paid to Carrier	66,152
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