

<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 style="text-align: center;"><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; text-align: center;"><b>2024</b></p> <hr/> <p style="text-align: center;"><b>This Form is Open to Public Inspection</b></p>
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**Part I Annual Report Identification Information**  
 For calendar plan year 2024 or fiscal plan year beginning 02/01/2024 and ending 01/31/2025

**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><b>1a</b> Name of plan <u>GROUP LONG TERM DISABILITY PLAN</u></p>	<p><b>1b</b> Three-digit plan number (PN) ▶ <u>506</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>KANSAS BANKERS SERVICES, INC.</u></p> <p style="text-align: center;"><u>PO BOX 4407</u> <span style="margin-left: 200px;"><u>610 SW CORPORATE VIEW</u></span> <u>TOPEKA, KS 66604</u> <span style="margin-left: 200px;"><u>TOPEKA, KS 66615</u></span></p>	<p><b>1c</b> Effective date of plan <u>12/01/1975</u></p> <p><b>2b</b> Employer Identification Number (EIN) <u>48-1233705</u></p> <p><b>2c</b> Plan Sponsor's telephone number <u>785-232-3444</u></p> <p><b>2d</b> Business code (see instructions) <u>522110</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.	11/16/2025	ELIZABETH ROCHE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	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

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<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>	6328
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</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>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	6328
	<b>6a(2)</b>	5836
	<b>6b</b>	
	<b>6c</b>	
	<b>6d</b>	5836
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<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:  
4H

<b>9a</b> Plan funding arrangement (check all that apply)	<b>9b</b> 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)

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

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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><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 **02/01/2024** and ending **01/31/2025**

<p><b>A</b> Name of plan <b>GROUP LONG TERM DISABILITY PLAN</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>506</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>KANSAS BANKERS SERVICES, INC.</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>48-1233705</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  
**SUN LIFE ASSURANCE COMPANY OF CANADA**

(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
38-1082080	80802	215840	5836	02/01/2024	01/31/2025

**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 <b>358760</b></p>	<p>(b) Total amount of fees paid <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  
**KBA INSURANCE INC** **PO BOX 4407**  
**TOPEKA, KS 66604**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
358760			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	

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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.
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<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>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b> 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. .... Specify nature of costs ▶	<b>6d</b>	

**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>	
	<b>7c(6)</b>	<b>0</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: (1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
	<b>7e(5)</b>	<b>0</b>
<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>	1574146
<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 **02/01/2024** and ending **01/31/2025**

- 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.)
- 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 <b>GROUP LONG TERM DISABILITY PLAN</b>	<b>1b</b> Three-digit plan number (PN) ▶ <b>506</b>
<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) <b>KANSAS BANKERS SERVICES, INC.</b>  <b>PO BOX 4407</b>  <b>TOPEKA KS 66604</b>	<b>1c</b> Effective date of plan <b>12/01/1975</b>  <b>2b</b> Employer Identification Number (EIN) <b>48-1233705</b>  <b>2c</b> Plan Sponsor's telephone number <b>7852323444</b>  <b>2d</b> Business code (see instructions) <b>522110</b>

**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>	<i>Elizabeth Roche</i>	<b>11/16/2025</b>	<b>ELIZABETH ROCHE</b>
	<b>Signature of plan administrator</b>	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	<b>Signature of employer/plan sponsor</b>	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	<b>Signature of DFE</b>	Date	Enter name of individual signing as DFE

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

Form 5500 (2024)  
v. 240311

Kansas Bankers Association  
Long Term Disability Plan  
Multiple-Employer Participating Employer Information  
Plan 506  
EIN: 48-1233705

BANK	TAX ID #
ASTRA BANK	48-0405814
ASTRA BUSINESS SOLUTIONS	20-2737143
ANDOVER STATE BANK	48-0122265
UNION STATE BANK	48-0456370
STOCKGROWERS STATE BANK	48-0439010
EXCHANGE BANK	48-0212120
BALDWIN STATE BANK	48-0129620
MID AMERICA BANK	48-0435820
AMERICAN BANK	48-0119910
BAXTER STATE BANK	48-0133900
NEW CENTURY BANK	48-0345880
FIRST BANK OF BELOIT	48-0136796
GUARANTY STATE BANK	48-0246590
BENDENA STATE BANK	48-0137140
THE STATE BANK OF BERN	48-0435720
FARMERS STATE BANK	48-0216400
PRAIRIE BANK OF KANSAS	48-0216090
STATE BANK OF BURRTON	48-0518993
STOCK EXCHANGE BANK	48-0438970
STATE BANK OF CANTON	48-0435760
COTTONWOOD VALLEY BANK	48-0163260
FIRST HERITAGE BANK	48-0221210
BANK OF COMMERCE	48-0998823
COMMUNITY NATIONAL BANK & TRUST	48-1038713
HOME SAVINGS BANK	48-0165559
CITIZENS STATE BANK	48-0169030
PEOPLES STATE BANK	48-0369640
FIRST NATIONAL BANK	48-0168292
UNION STATE BANK	48-0456380
COMMUNITY STATE BANK	48-0731367
FARMERS & MERCHANTS BANK OF COLBY	48-1197397
PEOPLES BANK	48-0369650
THE ELK STATE BANK	48-0207620
THE CITIZENS NATIONAL BANK	48-0168925
CONWAY BANK	48-0180195
FARMERS AND DROVERS BANK	48-0214960
SWEDISH AMERICAN STATE BANK	48-0443660
NINNESCAH VALLEY BANK	48-0187483
TRI CENTURY BANK	48-0770544
BANK OF DENTON	48-0130270
FIRST NATIONAL BANK	48-0196365
FIDELITY STATE BANK	48-0219680
STATE BANK OF DOWNS	48-0435810
CITIZENS STATE BANK & TRUST	48-0169050
ESB FINANCIAL	48-0209570
LYON COUNTY STATE BANK	48-0316640
KAW VALLEY STATE BANK	48-0292660

Kansas Bankers Association  
Long Term Disability Plan  
Multiple-Employer Participating Employer Information  
Plan 506  
EIN: 48-1233705

BANK	TAX ID #
HOME BANK & TRUST CO	48-0266459
FARMERS STATE BANK	48-0216460
CITY STATE BANK	48-0170660
LANDMARK NATIONAL BANK	48-0319663
INTEGRITY BANK	48-0225700
FIRST NATIONAL BANK	48-0227595
FARMERS STATE BANK	48-0216470
VALLEY STATE BANK	48-0459220
PATRIOTS BANK	48-0364530
FNB BANK	48-0220810
BANKWEST OF KANSAS	48-0239760
BANK OF THE PLAINS	48-0376280
FARMERS BANK & TRUST	48-0216340
BANK OF GREELEY	48-0130310
CITIZENS STATE BANK	48-0169100
THE HALSTEAD BANK	48-0249420
HAVILAND STATE BANK	48-0255670
BANK OF HAYS	48-0251270
GOLDEN BELT BANK	48-0238885
FIRST STATE BANK	48-0221480
CITIZENS STATE BANK	48-0169120
FIRST KANSAS BANK	48-0697156
FIRST STATE BANK	48-0221530
GNBANK	48-0237220
DENISON STATE BANK	48-0193755
FIRST NATIONAL BANK	48-0220942
HOWARD STATE BANK	48-0270091
CITIZENS STATE BANK	48-0169130
THE FIRST NATIONAL BANK OF HUTCHINSON	48-0273305
FIRSTOAK BANK	48-0207525
JOHNSON STATE BANK	48-0283520
DREAM FIRST BANK	48-0444740
ARGENTINE FEDERAL SAVINGS	48-0123640
KANZA BANK	48-0296945
KCB BANK	48-0292810
FUSION BANK	48-0221500
GREAT AMERICAN BANK	48-1218768
CITIZENS FEDERAL SAVINGS BANK	48-0168910
PROF BANK CONSULTANTS LLC	20-1897871
SMALL BUSINESS BANK	48-0978679
THE COMMUNITY BANK	48-1214912
FIRST NATIONAL BANK	48-0314805
LYNDON STATE BANK	48-0316470
LYONS FEDERAL BANK	48-0316730
KS STATEBANK	48-0760380
STOCKGROWERS STATE BANK	48-0439020
MARION NATIONAL BANK	48-0321073

Kansas Bankers Association  
Long Term Disability Plan  
Multiple-Employer Participating Employer Information  
Plan 506  
EIN: 48-1233705

BANK	TAX ID #
MARQUETTE FARMERS ST BANK	48-0216590
CITIZENS STATE BANK	48-0169180
FIRST COMMERCE BANK	81-0560206
BENNINGTON STATE BANK	48-0137740
CENTERA BANK	48-0254786
FARMERS & MERCHANTS BANK	48-0215570
THE CITIZENS STATE BANK	48-0169210
CARSON BANK	48-0345810
FIRST STATE BANK	48-0350335
THE FARMERS STATE BANK	48-0216780
THE BANK	48-1008896
MAINSTAR TRUST	05-0527466
KANSAS STATE BANK	48-0290620
FIRST SECURITY BANK	48-0221050
KANSAS VENTURE CAPITAL	48-0852197
FIRST OPTION BANK	48-0359685
LABETTE BANK	48-0301840
COMMERCIAL BANK	48-0365170
FARMERS STATE BANK	48-0216690
FIRST NATIONAL BANK	48-0374465
BANK OF PRAIRIE VILLAGE	48-0254080
THE PEOPLES BANK	48-0369245
PRESCOTT STATE BANK	48-0379570
BANK OF PROTECTION	48-0901316
FIRST STATE BANK	48-0221560
RILEY STATE BANK	48-0489884
ROXBURY BANK	48-0398105
SOUTHWIND BANK	48-0348973
SJN BANK OF KANSAS	48-0402277
EXCHANGE STATE BANK	48-0212180
FIRST BANK KANSAS	48-0579043
FIRST NATIONAL BANK	48-0408825
SECURITY STATE BANK	48-0669594
ELEVATE BANK	48-0410055
COMMUNITY NATIONAL BANK	48-0976372
SOLOMON STATE BANK	48-0427000
FIRST NATIONAL BANK	48-0430106
FORD COUNTY STATE BANK	48-0223990
STATE BANK OF SPRING HILL	48-0436070
ALDEN STATE BANK	48-0117360
FIRST BANK	48-0508207
SOLUTIONS NORTH BANK	48-0439085
TAMPA STATE BANK	48-0445180
FIRST STATE BANK	48-0451049
KANSAS BANKERS SERVICES, INC.	48-1233705
ALLIANCE BANK	48-1202871
FIDELITY STATE BANK & TRUST CO	48-0219655

Kansas Bankers Association  
Long Term Disability Plan  
Multiple-Employer Participating Employer Information  
Plan 506  
EIN: 48-1233705

BANK	TAX ID #
HERITAGE BANK	48-1305893
KAW VALLEY BANK	48-0292680
GRANT COUNTY BANK	48-0241960
UNION STATE BANK	48-0456410
WALTON ST BANK	48-0464710
BANK OF THE FLINT HILLS	48-0464795
KAW VALLEY STATE BANK	48-0292690
FARMERS STATE BANK	48-0216710
FIRST NATIONAL BANK OF KANSAS	48-0467060
CBW	48-0168770
BANK OF COMMERCE	48-0347860
IMPACT BANK	48-0468914
SECURITY STATE BANK	48-0410030
LEGACY BANK	48-0435770
BANKERS BANK OF KANSAS	48-1005423
COOPER, MALONE AND MCCLAIN	48-1024628
GARDEN PLAIN STATE BANK	48-0726234
JUNIPER PAYMENTS, LLC DBA LendingTools.com	82-0967186
STRYV BANK	48-0815007
TRUST COMPANY OF KANSAS	48-1083639
VINTAGE BANK KANSAS	48-0435960
WILSON STATE BANK	48-0481585