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 05/01/2024 and ending 04/30/2025

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

B This return/report is:
- ☐ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

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

D Check box if filing under:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
ENDAVA SOLUTIONS, LLC CIGNA

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 05/01/2024

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)
ENDAVA SOLUTIONS, LLC

KELLY DIZINNO

270 DAVIDSON AVE
SOMERSET, NJ 08873-4140

270 DAVIDSON AVE
SOMERSET, NJ 08873-4140

2b Employer Identification Number (EIN)
27-0022071

2c Plan Sponsor's telephone number
908-879-4600

2d Business code (see instructions)
541990

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.	11/25/2025	KELLY DIZINNO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	11/25/2025	KELLY DIZINNO
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name GALAXY SYSTEMS, INC.

c Plan Name GALAXY SYSTEMS, INC., CIGNA

4b EIN 13-3583090

4d PN 502

5	Total number of participants at the beginning of the plan year	**5**	313
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	309
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	278
b	Retired or separated participants receiving benefits	**6b**	5
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	283
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	283
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

4A 4D 4E

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 05/01/2024 and ending 04/30/2025

A Name of plan
ENDAVA SOLUTIONS, LLC CIGNA

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
ENDAVA SOLUTIONS, LLC

D Employer Identification Number (EIN)
27-0022071

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
CIGNA HEALTH AND 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
59-1031071	67369	3337861	641	05/01/2024	04/30/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
223352	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

CHAS E RUE & SON TA RUE INSURANCE
3812 QUAKERBRIDGE ROAD
HAMILTON, NJ 08619

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
223352	0		3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [X] Dental
- **c** [X] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [X] 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)**	252257		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	2680		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	254937
b Benefit charges (1) Claims paid	**9b(1)**	201176		
(2) Increase (decrease) in claim reserves	**9b(2)**	-140370		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	60806
(4) Claims charged			**9b(4)**	60806
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)**	319414		
(E) Taxes	**9c(1)(E)**	1515		
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	320929
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	587226
(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**	1648286
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

Cigna Health and Life Insurance Company
A Cigna Company
Hartford, CT 06152

Schedule A Insurance Information

Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator

A. Plan Name:	GALAXY SYSTEMS, INC. / ENDAVA SOLUTIONS, LLC (as of 02/28/2025)	B. Three-Digit Plan Number (P/N):	Plan will provide
C. Plan Sponsor's Name:	Plan will provide	D. Company Identification Number:	Plan will provide

PART I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)

1. Coverage Information — (a) Name of insurance carrier: Cigna Health and Life Insurance Company and affiliates ("Cigna")

(b) EIN	(c) NAIC Code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract period	Policy or contract year (f) From (g) Through
59-1031071	67369	3337861	641 Persons	5/1/2024 - 4/30/2025

2. Insurance fees and commissions information. Enter total fees and commissions paid.

(a) Total amount of commissions paid	223,352		(b) Total amount of fees paid	0

3. Persons receiving commissions and fees. (a) Name and address of the agent, broker or other person to whom commissions or fees were paid	(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount*	(d) Purpose*	(e) Organization code
		*Refer to footnotes for incentive $$ amounts and purpose as applicable		
Experience-Rated				
CHAS E RUE & SON INC / HAMILTON, NJ	212,311	0		3-Insurance Agent or Broker
Non Experience-Rated				
CHAS E RUE & SON INC / HAMILTON, NJ	11,041	0		

Outstanding Monies Due $ 2,680 — Contract or Identification Number same as 1d

PART III Welfare Benefit Contract Information:

8. Benefit and contract type

- [x] (a) Health (other than dental or vision)
- [x] (b) Dental
- [x] (c) Vision
- [ ] (d) Life Insurance
- [ ] (e) Temporary disability (accident and sickness)
- [ ] (f) Long-term disability
- [ ] (g) Supplemental unemployment
- [x] (h) Prescription Drug
- [ ] (i) Stop loss (large deductible)
- [x] (j) HMO Contract
- [ ] (k) PPO contract
- [x] (l) Indemnity Contract
- [x] (m) Other (Prepaid Dental)

9. Experience-Rated Contracts

(a) Premiums	(1) Amount received	252,257	
	(2) Increase (decrease) in amount due but unpaid		
	Premium Due as of 7/17/2025	0	
	Retrospective Premium or Bank Account Margin Due	2,680	
	(4) Earned, ((1) + (2) = (4))		254,937
(b) Benefit charges	(1) Claims Paid	201,176	
	(2) Increase (decrease) in claim reserves	(140,370)	
	(3) Incurred claims, (add (1) and (2))	60,806	
	(4) Claims charged		60,806
(c) Remainder of premium	(1) Retention charges (on an accrual basis)		
	(A) Contracted Commissions	0	
	(B) Administrative service or other fees	0	
	(D) Other Expenses	319,414	
	(E) Taxes (Approx)	1,515	
	(H) Total retention		320,929
	(2) Dividends or retroactive rate refunds (these amounts were 1) paid in cash)		0
	Dividends or retroactive rate refunds (these amounts were 2) credited to Premium Stabilization Reserve)		0
	Dividends or retroactive rate refunds (these amounts were 2) credited to other reserves)		0
	Dividends or retroactive rate refunds (these amounts were 2) credited to accumulated deficits)		0
	Deficits arising from experience in current policy reporting year		198,496
	Accumulated deficits arising from experience in current and previous policy reporting years		198,506
(d) Status of policyholder reserves at end of year	(2) Claim reserves		587,226
	(3) Other reserves (Premium Stabilization Reserve)		0
	Other reserves		0
(e) Dividends or retroactive rate refunds due. (Do not include amount entered in 9c(2).)			0
from ☐ Premium Stabilization Reserve ☐ Other Reserves			
to ☐ Credited to policy year premium ☐ Credited to offset deficit ☐ Paid in cash			
10. Non-Experience Rated Contracts	(a) Total Premiums or subscriptions charges paid to carrier		1,648,286
	Premium Due as of 7/17/2025		0
	(b) If the carrier, service or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount		
	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. Not Applicable

THE INFORMATION REFLECTED IN THIS REPORT IS ACCURATE AND COMPLETE BASED UPON INFORMATION AVAILABLE TO CIGNA COMPANIES AT THE TIME THIS REPORT IS PREPARED AND IS CERTIFIED AS BEING COMPLETE AND ACCURATE.

NOTE TO POLICYHOLDERS: You may have responsibilities under law to determine whether the information contained in this report could be used to identify individuals either when combined with other information that you have or in any other manner and, if so, to take appropriate protective steps.

"Cigna" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

Cigna Health and Life Insurance Company
A Cigna Company
Hartford, CT 06152

Schedule A Insurance Information Footnotes

Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator

A. Plan Name:	GALAXY SYSTEMS, INC.	B. Three-Digit Plan Number (P/N):	Plan will provide
C. Plan Sponsor's Name:	Plan will provide	D. Company Identification Number:	Plan will provide

PART I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)

1. Coverage Information (a) Name of insurance carrier: Cigna Health and Life Insurance Company and affiliates ("Cigna")

(b) EIN	(c) NAIC Code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract period	Policy or contract year (f) From (g) Through
59-1031071	67369	3337861	641 Persons	5/1/2024 - 4/30/2025

(Part I, line 1a) "Name of Insurance Carrier", (b) "EIN", (c) "NAIC Code" - The plan to which this report applies may be funded by contracts issued by more than one Cigna company each of which is an "insurance carrier." The issuance of multiple insurance carrier contracts is necessary to cover individuals who participate in the same plan but reside in different geographic locations. As the Cigna companies whose contracts fund the plan are grouped as a single unit by Cigna for purposes of underwriting the plan, combining the information with respect to these individual contracts in this report will provide more meaningful insurance information for the Schedule A. The individual contracts of the Cigna companies are grouped as a unit for purposes of this report. To reference individual contracts refer to the Appendix pages contained within this reporting package.

(Part I, line 1e) Schedule A subscriber/employee/participant and persons/members information is available for your contract policy year on the employer portal at www.cignaaccess.com, report titled, Subscriber and Membership Reporting.

(Part I, line 2a, 2b, 3b and/or 3c) Represents the amount of commission paid during the contract year. This amount is reflective of payments made during the contract year that may be attributable to multiple contract years.

(Part I, line 2a, 2b) The following amounts were paid to your broker(s) / consultant(s) during the contract year:
Commissions: $11,041
Service/Gen.Agent Fees: $0
Benefit Advisor Fees: $212,311
Benefit Advisor Fees are not included as part of premium.

(Line 9.b.1) May include pay for performance payments to providers, vendor cost-containment, administrative and care coordination fees.

(Line 10.a) May reflect amounts paid for surcharges on provider charges or other assessments imposed under applicable state law.

(Line 10.a) May include adjustment amounts attributable to another Cigna company whose coverage may have previously terminated.

- In addition to the commissions and fees reported, Cigna enters into compensation programs under which certain agents and brokers provide our companies with market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific policies, is funded from our general overhead, and is not required to be reported on Schedule A. Your agent or broker may also have participated, at our expense, in events we sponsor to inform them on our products and services.In addition, Cigna offers agents/ broker the opportunity to receive the benefit of Cigna's favorable pricing with vendors of various goods and services. Contact your agent/ broker for specific information about their participation.
- If the contract is a minimum premium insurance policy issued by Cigna, the “claims paid” are identified in the Bank Account Reconciliation Report for the last month of the contract year. Fees reported in Section 9 do not include fees paid to all overpayment recovery vendors based upon a percentage of recoveries.
- Certain non-claim fees paid from your benefit payment account are included as claims in your settlement but not included as claims in the ERISA Form 5500 Schedule A report (provided to ERISA plans) and the Annual Reconciliation Disclosure (provided to non-ERISA plans). As a result there may be a discrepancy between the amount of claims reflected in your settlement and on the Schedule A and Annual Reconciliation Document. A report to reconcile this discrepancy is available upon request.
- The deficit / margin is calculated including "PREMIUMS DUE BUT UNPAID".
- The contract holder is not entitled to a return of any premium or other payment made to a Cigna company unless the Cigna company has otherwise agreed in writing. The Cigna companies may use payments received for any purpose in their sole discretion.
- If the contract holder is a Public Entity located in California, you are asked to forward this report to the governing board.
- Appendix to Schedule A entities' allocation is based on averaged premium, commissions and available lives reported during the contract period.
- Appendix to Schedule A entities' allocation for broker/general agent commission amounts do not include Platinum/Supplemental bonus payments as they are paid lump sum to brokers/general agents and are included on the Schedule A summary page reporting.
- Appendix to Schedule A entities' reports the number of employees covered rather than employees and dependents.
- When referencing (Line 10.a) on the appendix page, please note, it may include adjustment amounts attributable to another Cigna company whose coverage may have previously terminated. Adjustments are allocated to a Cigna company whose coverage is active based on weighted average employees.
- The premium reported does not reflect the rebates, if any, under the Patient Protection and Affordable Care Act that may have been paid and credited for any prior plan year.
- Premium also includes taxes, fees and assessments imposed under the federal Patient Protection and Affordable Care Act.
- Does not include value-based payments made to entities not contracted as participating providers.
- Premium and commission associated with insurance coverage for an Employee Assistance Plan, if applicable, is included in this report.

Cigna Health and Life Insurance Company
A Cigna Company
Hartford, CT 06152

Schedule A Insurance Information - Appendix to Part I, Line Items 1a, b and c

A. Plan Name GALAXY SYSTEMS, INC.	
1. Coverage Information (d) Contract or Identification Number 3337861	Policy/Contract Year (f) From (g) Through 5/1/2024 - 4/30/2025

The below information is to further detail the non-experience rated premium for 5500 reporting based on applicable NAIC code:

	Company Information	5500 Section	5500 Line Item	DHMO Plan
Name:	Cigna Dental Health of California, Inc.	Part I	line 1(e)	1 employee
EIN Code:	59-2600475		line 2(a)	$ 16
NAIC Code:	N/A		line 2(b)	$ 0
			line 3(a)	CHAS E RUE & SON INC / HAMILTON, NJ
			line 3(b)	$ 16
			line 3(c)	$ 0
		Part III	line 10(a)	$ 574

	Company Information	5500 Section	5500 Line Item	DHMO Plan
Name:	Cigna Dental Health of Missouri, Inc.	Part I	line 1(e)	5 employees
EIN Code:	06-1582068		line 2(a)	$ 88
NAIC Code:	11160		line 2(b)	$ 0
			line 3(a)	CHAS E RUE & SON INC / HAMILTON, NJ
			line 3(b)	$ 88
			line 3(c)	$ 0
		Part III	line 10(a)	$ 1,721

	Company Information	5500 Section	5500 Line Item	DHMO Plan
Name:	Cigna Dental Health of New Jersey, Inc.	Part I	line 1(e)	54 employees
EIN Code:	59-2308062		line 2(a)	$ 1,015
NAIC Code:	11167		line 2(b)	$ 0
			line 3(a)	CHAS E RUE & SON INC / HAMILTON, NJ
			line 3(b)	$ 1,015
			line 3(c)	$ 0
		Part III	line 10(a)	$ 21,230

	Company Information	5500 Section	5500 Line Item	DHMO Plan
Name:	Cigna Dental Health of Pennsylvania, Inc.	Part I	line 1(e)	5 employees
EIN Code:	52-1220578		line 2(a)	$ 93
NAIC Code:	47041		line 2(b)	$ 0
			line 3(a)	CHAS E RUE & SON INC / HAMILTON, NJ
			line 3(b)	$ 93
			line 3(c)	$ 0
		Part III	line 10(a)	$ 1,721

	Company Information	5500 Section	5500 Line Item	DHMO Plan
Name:	Cigna Dental Health of Maryland, Inc.	Part I	line 1(e)	2 employees
EIN Code:	59-2740468		line 2(a)	$ 28
NAIC Code:	48119		line 2(b)	$ 0
			line 3(a)	CHAS E RUE & SON INC / HAMILTON, NJ
			line 3(b)	$ 28
			line 3(c)	$ 0
		Part III	line 10(a)	$ 574

	Company Information	5500 Section	5500 Line Item	DHMO Plan
Name:	Cigna Dental Health of Florida, Inc.	Part I	line 1(e)	8 employees
EIN Code:	59-1611217		line 2(a)	$ 151
NAIC Code:	52021		line 2(b)	$ 0
			line 3(a)	CHAS E RUE & SON INC / HAMILTON, NJ
			line 3(b)	$ 151
			line 3(c)	$ 0
		Part III	line 10(a)	$ 3,443

Cigna Health and Life Insurance Company
A Cigna Company
Hartford, CT 06152

Schedule A Insurance Information - Appendix to Part I, Line Items 1a, b and c

A. Plan Name GALAXY SYSTEMS, INC.	
1. Coverage Information (d) Contract or Identification Number 3337861	Policy/Contract Year (f) From (g) Through 5/1/2024 - 4/30/2025

The below information is to further detail the non-experience rated premium for 5500 reporting based on applicable NAIC code:

	Company Information	5500 Section	5500 Line Item	DHMO Plan
Name:	Cigna Dental Health of Kansas, Inc.	Part I	line 1(e)	1 employee
EIN Code:	59-2625350		line 2(a)	$ 24
NAIC Code:	52024		line 2(b)	$ 0
			line 3(a)	CHAS E RUE & SON INC / HAMILTON, NJ
			line 3(b)	$ 24
			line 3(c)	$ 0
		Part III	line 10(a)	$ 574

	Company Information	5500 Section	5500 Line Item	DHMO Plan
Name:	Cigna Dental Health of Kentucky, Inc.	Part I	line 1(e)	3 employees
EIN Code:	59-2619589		line 2(a)	$ 54
NAIC Code:	52108		line 2(b)	$ 0
			line 3(a)	CHAS E RUE & SON INC / HAMILTON, NJ
			line 3(b)	$ 54
			line 3(c)	$ 0
		Part III	line 10(a)	$ 1,148

	Company Information	5500 Section	5500 Line Item	DHMO Plan
Name:	Cigna Dental Health of Texas, Inc.	Part I	line 1(e)	1 employee
EIN Code:	59-2676977		line 2(a)	$ 8
NAIC Code:	95037		line 2(b)	$ 0
			line 3(a)	CHAS E RUE & SON INC / HAMILTON, NJ
			line 3(b)	$ 8
			line 3(c)	$ 0
		Part III	line 10(a)	$ -1

	Company Information	5500 Section	5500 Line Item	DHMO Plan
Name:	Cigna HealthCare of Connecticut, Inc.	Part I	line 1(e)	33 employees
EIN Code:	06-1141174		line 2(a)	$ 621
NAIC Code:	95660		line 2(b)	$ 0
			line 3(a)	CHAS E RUE & SON INC / HAMILTON, NJ
			line 3(b)	$ 621
			line 3(c)	$ 0
		Part III	line 10(a)	$ 13,197

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 05/01/2024 and ending 04/30/2025

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

B This return/report is:
- ☐ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

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

D Check box if filing under:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
ENDAVA SOLUTIONS, LLC CIGNA

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 05/01/2024

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)
ENDAVA SOLUTIONS, LLC

KELLY DIZINNO
270 DAVIDSON AVE
SOMERSET, NJ 08873-4140

270 DAVIDSON AVE
SOMERSET, NJ 08873-4140

2b Employer Identification Number (EIN)
27-0022071

2c Plan Sponsor's telephone number
908-879-4600

2d Business code (see instructions)
541990

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	Kelly Dizinno	11/25/25	Kelly Dizinno
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Kelly Dizinno	11/25/25	Kelly Dizinno
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor	**3b** Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **a** Sponsor's name GALAXY SYSTEMS, INC. **c** Plan Name GALAXY SYSTEMS, INC., CIGNA	**4b** EIN 13-3583090 **4d** PN 502	
5 Total number of participants at the beginning of the plan year	**5**	313
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1) Total number of active participants at the beginning of the plan year	**6a(1)**	309
a(2) Total number of active participants at the end of the plan year	**6a(2)**	278
b Retired or separated participants receiving benefits	**6b**	5
c Other retired or separated participants entitled to future benefits	**6c**	
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	283
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f Total. Add lines **6d** and **6e**.	**6f**	283
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

4A 4D 4E

9a Plan funding arrangement (check all that apply)	**9b** Plan benefit arrangement (check all that apply)
(1) [X] Insurance	(1) [X] Insurance
(2) [ ] Code section 412(e)(3) insurance contracts	(2) [ ] Code section 412(e)(3) insurance contracts
(3) [ ] Trust	(3) [ ] Trust
(4) [ ] General assets of the sponsor	(4) [ ] General assets of the sponsor

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

a Pension Schedules

(1) [ ] **R** (Retirement Plan Information)

(2) [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary

(3) [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

(4) [ ] **DCG** (Individual Plan Information) – Number Attached _____

(5) [ ] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

(1) [ ] **H** (Financial Information)

(2) [ ] **I** (Financial Information – Small Plan)

(3) [X] **A** (Insurance Information) – Number Attached 1

(4) [ ] **C** (Service Provider Information)

(5) [ ] **D** (DFE/Participating Plan Information)

(6) [ ] **G** (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code _____