

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.

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, a single-employer plan, a DFE, the first return/report, the final return/report, an amended return/report, a short plan year return/report.
B This return/report is: the first return/report, the final return/report, an amended return/report, a short plan year return/report.
C If the plan is a collectively-bargained plan, check here.
D Check box if filing under: Form 5558, automatic extension, special extension, the DFVC program.
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: AIRPORT SHOPPES, CORP. WELFARE BENEFITS PLAN
1b Three-digit plan number (PN): 502
1c Effective date of plan: 01/01/2013
2a Plan sponsor's name, mailing address, city or town, state or province, country, and ZIP or foreign postal code.
2b Employer Identification Number (EIN): 66-0430612
2c Plan Sponsor's telephone number: 787-791-2615
2d Business code (see instructions): 722300

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.

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes rows for employer/plan sponsor and DFE.

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

Form 5500 (2024) v. 240311

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	829
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)	829
	6a(2)	936
	6b	
	6c	
	6d	936
	6e	
	6f	936
	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:

4A 4B 4Q

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**
- (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) **A** (Insurance Information) – Number Attached 2
 - (4) **C** (Service Provider Information)
 - (5) **D** (DFE/Participating Plan Information)
 - (6) **G** (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan AIRPORT SHOPPES, CORP. WELFARE BENEFITS PLAN		B Three-digit plan number (PN) ▶ 502
C Plan sponsor's name as shown on line 2a of Form 5500 AIRPORT SHOPPES, CORP.		D Employer Identification Number (EIN) 66-0430612

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
HARTFORD LIFE AND ACCIDENT

(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
06-0838648	70815	879344G	936	12/01/2023	11/30/2024

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.

(a) Total amount of commissions paid 6095	(b) Total amount of fees paid 1657
--	---

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
FULCRO INSURANCE PO BOX 9024048
SAN JUAN, PR 00901

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
6905		BROKERAGE	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
INNOVA INSURANCE SERVICES INC PMB 234 AVE. ESMERALDA 405
SUITE 2
GUAYNABO, PR 00969

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	1657	GENERAL AGENCY	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	

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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.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits..... **7c(2)**
 (3) Interest credited during the year..... **7c(3)**
 (4) Transferred from separate account **7c(4)**
 (5) Other (specify below)..... **7c(5)**
 ▶

(6) Total additions **7c(6)**

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier..... **7e(2)**
 (3) Transferred to separate account **7e(3)**
 (4) Other (specify below)..... **7e(4)**
 ▶

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

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

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** 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	
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 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.**

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OMB No. 1210-0110

2024

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A Name of plan AIRPORT SHOPPES, CORP. WELFARE BENEFITS PLAN		B Three-digit plan number (PN) ▶ 502
C Plan sponsor's name as shown on line 2a of Form 5500 AIRPORT SHOPPES, CORP.		D Employer Identification Number (EIN) 66-0430612

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
MCS 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
66-0520918	60030	791659	429	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 60833	(b) Total amount of fees paid 11000
---	--

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

PULCRO INSURANCE
PO BOX 9024048
SAN JUAN, PR 00902

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
55001		BROKERAGE	3

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

AON RISK SOLUTIONS OF PR, INC
PO BOX 191229
SAN JUAN, PR 00918

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5831		BROKERAGE	3

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

CGF INSURANCE, LLC

CAPARRA OFFICE CENTER
 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	
	11000	GENERAL AGENCY	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.
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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. Specify nature of costs ▶	6d	

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) ▶ MAJOR MEDICAL, ORGAN TRANSPLANT

9 Experience-rated contracts:

a Premiums: (1) Amount received		9a(1)	1209319
(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)	1209319
b Benefit charges (1) Claims paid		9b(1)	1099056
(2) Increase (decrease) in claim reserves		9b(2)	13392
(3) Incurred claims (add (1) and (2))		9b(3)	1112448
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)	60833	
(B) Administrative service or other fees	9c(1)(B)	120564	
(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)		181397
(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
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. ▶



**Information to Complete ERISA
Form 5500**

MCS Life Insurance Company
P.O. Box 9023547
San Juan, P.R. 00902-3547
787.758.2500

Wednesday, January 15, 2025
AIRPORT SHOPPES
PO BOX 37779 AIRPORT STA.
SAN JUAN PR 00937

Information Concerning Insurance Contract Coverage of Administrative Services, Fees and Commissions.

* This information has the purpose to help you complete your filing obligations under ERISA

General Information

a) Company Name	MCS Life Insurance Company
b) EIN	66-0520918
c) NAIC Code	60030
d) Contract or identification number:	791659
e) Approximate number of contracts covered at beginning and end of policy or contract year:	429 - 426
f) Policy or contract year:	5/1/2024 - 4/30/2025
g) Contract Type:	Fully Insured
h) Benefit and Contract Type:	Health, Dental, Life Insurance, Prescription Drug, PPO Contract

Broker Information

a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

FULCRO INSURANCE INC PO BOX 9024048 SAN JUAN PR 00902-4048	55,001.51
Aon Risk Solutions Of Pr, Inc. PO BOX 191229 SAN JUAN PR 0091-1229	5,831.75

1. Amount of Estimated Commissions: \$ 60,833.26

Cgf Insurance, Llc CAPARRA OFFICE CENTER, SUITE 200 GUAYNABO PR 00968-3011	2. Amount of Estimated Fees	\$ 11,000.30
--	-----------------------------	--------------

Benefit Charges:

1. Claims Paid	\$ 1,099,056.57
2. Increase (Decrease) in claim reserves	\$ 13,392.84
Total Claims Paid	\$ 1,112,449.41

Reinsurance Information:

1. Stop Loss	\$ -
2. Organ Transplant	\$ -

Premium and Retention Information

a) Premium Received	\$ 1,209,319.35
b) Retention Charges:	
1. Total Commissions	\$ 60,833.26
2. Administrative Fee or other services	\$ 120,564.66
Total Retention	\$ 181,397.90



The Hartford
 GBD Producer Services
 P.O.Box 2999
 Hartford, CT 06104-2999

February 3, 2025

AIRPORT SHOPPES CORPORATION
 GLENDA SOLA
 PO BOX 37779
 SAN JUAN, PR 00937-0779

Dear Policyholder

We've attached your certified Annual Statement of Premiums and Producer Compensation group benefits summary. The summary is useful when completing and filing an IRS Form 5500 Schedule A. The Hartford certifies the accuracy and completeness of the information provided.

To help you better understand your statement, we've defined some of the terms used in the report.

TERM:	DEFINITION:
Premiums	Payments paid and applied during the policy year
Commissions	Base paid to your insurance producer on premiums received and applied during the policy year
Fees Record as "Fees" on IRS Form 5500 Schedule A	Payments to your insurance producer for administrative or other services related to your policy including General Agent override compensation
Bonus Paid Record as "Fees" on IRS Form 5500 Schedule A	Contingent compensation (cash or non-cash) payable to producers on all policies that were considered in determining the producer's eligibility for bonus payments and/or the actual calculation of any such bonus payment
Additional Compensation Record as "Fees" on IRS Form 5500 Schedule A	Non-contingent compensation (cash or non-cash) payable to producers on all policies that were considered in determining the producer's eligibility for additional compensation and/or the actual calculation of any such additional compensation

We appreciate your business and look forward to serving your group benefit needs. Please contact your Hartford representative or call Customer Service at (800) 523-2233 if you have any questions. You can also e-mail us at: gbdcommissions@hartfordlife.com.

Sincerely,

Jonathan Pintoff
 Assistant Vice President
 Service Operations
 P.O. Box 2999
 Hartford, CT 06104-2999

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting company Hartford Life and Accident Insurance Company under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at www.thehartford.com. The Hartford is the administrator for certain group benefits business written Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). © 2022 The Hartford

The Hartford
Group Benefits Division
Annual Statement of Premiums and Producer Compensation
For: AIRPORT SHOPPES CORPORATION
Page 2 of 3



Policyholder and Address

AIRPORT SHOPPES CORPORATION
PO BOX 37779
SAN JUAN, PR 00937-0779

Plan/Policy Year - 12/01/2023 to 11/30/2024

Name of Insurance Carrier	EIN	NAIC Code	Policy Number
HARTFORD LIFE AND ACCIDENT	06-0838648	70815	879344G

Premium was applied as follows during the Plan/Policy Year -

Policy Number	Type of Benefit	Premium Applied	Approximate # of Lives Covered
879344G	ADD-BAS	\$3,662.83	936
879344G	LIFE-BTRM	\$23,958.03	936
	Total	\$27,620.86	

The Hartford
Group Benefits Division
Annual Statement of Premiums and Producer Compensation
For: AIRPORT SHOPPES CORPORATION
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Insurer paid the following compensation during the Plan/Policy Year -

Producer and Address	Org Code	Policy Number	Commissions Paid	Fees Paid	(1) Bonus Paid	(2) Additional Compensation Paid
INNOVA INSURANCE SERVICES INC PO BOX 299 MERCEDITA, PR 00715	3	879344-0GL	\$0.00	\$1,657.27	\$0.00	\$0.00
		Total	\$0.00	\$1,657.27	\$0.00	\$0.00

Producer and Address	Org Code	Policy Number	Commissions Paid	Fees Paid	(1) Bonus Paid	(2) Additional Compensation Paid
FULCRO INSURANCE, INC. PO BOX 9024048 SAN JUAN, PR 00901	3	879344-0GL	\$6,905.29	\$0.00	\$0.00	\$0.00
		Total	\$6,905.29	\$0.00	\$0.00	\$0.00

(1) Bonus Paid represents an allocation of contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such bonus payment. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

(2) Additional Compensation represents an allocation of non-contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such additional compensation. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

The Hartford compensates producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation, including contingent commission and other non-cash awards. Incentive compensation is based upon a variety of factors that may include the level of premium written, retention and growth of premium, overall profitability, or other performance measures. Some of our producers elect not to accept some or all forms of compensation from The Hartford. Please direct specific questions about your insurance producer's compensation to your producer.