

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

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.

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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: [X] a multiemployer plan [] a multiple-employer plan... B This return/report is: [] a single-employer plan [] a DFE... C If the plan is a collectively-bargained plan, check here... [X] D Check box if filing under: [] Form 5558 [] automatic 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 SHEET METAL WORKERS LOCAL 7,ZONE 1 HEALTH & WELFARE PLAN
1b Three-digit plan number (PN) 501
1c Effective date of plan 01/01/1954
2a Plan sponsor's name (employer, if for a single-employer plan) SHEET METAL WORKERS,LOCAL 7,ZONE 1 HEALTH & WELFARE FUND
2b Employer Identification Number (EIN) 38-6099712
2c Plan Sponsor's telephone number 248-813-9800
2d Business code (see instructions) 813930

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

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

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

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

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

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

Receipt Confirmation Code _____

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

<p>A Name of plan SHEET METAL WORKERS LOCAL 7,ZONE 1 HEALTH & WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 SHEET METAL WORKERS,LOCAL 7,ZONE 1 HEALTH & WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 38-6099712</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
BLUE CROSS BLUE SHIELD OF MICHIGAN

(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
38-2069753	52429	248828	713	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid 45375</p>	<p>(b) Total amount of fees paid 0</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
DARRIS FRANK GAROUFALIX 700 TOWER DR STE 300 TROY, MI 48098

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
33415			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
BENESYS INC 700 TOWER DR STE 300 TROY, MI 48098

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
11960			3

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
	(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)	
(5) Total deductions	7e(5)	0
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	954729
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. ▶

**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 SHEET METAL WORKERS LOCAL 7,ZONE 1 HEALTH & WELFARE PLAN		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 SHEET METAL WORKERS,LOCAL 7,ZONE 1 HEALTH & WELFARE FUND		D Employer Identification Number (EIN) 38-6099712

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
THE UNION LABOR 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
13-1423090	69744	G3230	879		09/30/2024

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 0	(b) Total amount of fees paid 0
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

(b) 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	

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year			7b	
c Additions: (1) Contributions deposited during the year	7c(1)			
	7c(2)			
	7c(3)			
	7c(4)			
	7c(5)			
	(6) Total additions			
d Total of balance and additions (add lines 7b and 7c(6))			7d	
e Deductions:				
	7e(1)			
	7e(2)			
	7e(3)			
	7e(4)			
(5) Total deductions		7e(5)	0	
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) ▶ **ACCIDENTAL DEATH & DISMEMBERMENT**

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	32246
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. ▶

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider 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.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan SHEET METAL WORKERS LOCAL 7,ZONE 1 HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 SHEET METAL WORKERS,LOCAL 7,ZONE 1 HEALTH & WELFARE FUND	D Employer Identification Number (EIN) 38-6099712	

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... Yes No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

BLUE CROSS BLUE SHIELD OF MICHIGAN

38-2069753

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 15 16 23 50 62 99	THIRD-PARTY ADMINISTRATOR	484341	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

BENESYS

700 TOWER DR, STE 300
TROY, MI 48099-1218

38-2383171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 53	CONTRACT ADMINISTRATOR	142271	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

THE SEGAL COMPANY

2000 TOWN CENTER, SUITE 1900
SOUTHFIELD, MI 48075

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11	ACTUARY	33516	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

MANER COSTERISAN, P.C.

2425 E GRAND RIVER AVE
LANSING, MI 48912

38-2157642

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	AUDITOR	22386	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

FRANK D MCALPINE, ESQ.

610 UNIVERSITY DRIVE
EAST LANSING, MI 48823

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	ATTORNEY	15000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

STEFANSKY, HOLLOWAY & NICHOLS INC

22260 HAGGERTY ROAD, STE 350
NORTHVILLE, MI 48167

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
	ACCOUNTING	10468	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

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(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A Name of plan SHEET METAL WORKERS LOCAL 7,ZONE 1 HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 SHEET METAL WORKERS,LOCAL 7,ZONE 1 HEALTH & WELFARE FUND	D Employer Identification Number (EIN) 38-6099712

Part I	Asset and Liability Statement
---------------	--------------------------------------

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	7745104	10253618
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other.....	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	7745104	10253618
Liabilities			
g Benefit claims payable.....	1g		
h Operating payables.....	1h		
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j		
k Total liabilities (add all amounts in lines 1g through 1j).....	1k		
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	7745104	10253618

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	11345358	
(B) Participants.....	2a(1)(B)	450607	
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2).....	2a(3)		11795965
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	300	
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F).....	2b(1)(G)		300
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A), (B), and (C).....	2b(2)(D)		
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B).....	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		479228
d Total income. Add all income amounts in column (b) and enter total	2d		12275493

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	8196825	
(2) To insurance carriers for the provision of benefits	2e(2)	796368	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		8993193
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	611011	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	22386	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	33516	
(8) Legal fees	2i(8)	15001	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	91872	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		773786
j Total expenses. Add all expense amounts in column (b) and enter total	2j		9766979

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		2508514
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) Unmodified (2) Qualified (3) Disclaimer (4) Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d) (3) neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **MANER COSTERISAN P.C.**

(2) EIN: **38-2157642**

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) This form is filed for a CCT, PSA, DCG or MTIA. (2) It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
e Was this plan covered by a fidelity bond?	X		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)		X	
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		X	

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?..... Yes No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined
 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

**SHEET METAL WORKERS LOCAL 7, ZONE 1
HEALTH & WELFARE PLAN**

**REPORT ON FINANCIAL STATEMENTS
(with supplementary information)**

YEARS ENDED DECEMBER 31, 2024 AND 2023

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**SHEET METAL WORKERS LOCAL 7, ZONE 1 HEALTH & WELFARE PLAN
HIGHLIGHTS
SCHEDULES OF ADDITIONS TO PLAN ASSETS
YEARS ENDED DECEMBER 31, 2024, 2023 AND 2022**

	2024		2023		2022	
	Amount	Percent	Amount	Percent	Amount	Percent
Contributions, net of reciprocity	\$ 11,345,358	92	\$ 9,271,980	92	\$ 7,704,194	92
Member self-payments	450,607	4	359,062	4	414,271	5
Prescription drug rebates	479,228	4	379,707	4	276,826	3
Investment income	300	-	4,060	-	300	-
TOTAL ADDITIONS	<u>\$ 12,275,493</u>	<u>100</u>	<u>\$ 10,014,809</u>	<u>100</u>	<u>\$ 8,395,591</u>	<u>100</u>

**SHEET METAL WORKERS LOCAL 7, ZONE 1 HEALTH & WELFARE PLAN
HIGHLIGHTS
SCHEDULES OF DEDUCTIONS FROM PLAN ASSETS
YEARS ENDED DECEMBER 31, 2024, 2023 AND 2022**

	<u>2024</u>	<u>2023</u>	<u>2022</u>
Benefits			
Benefits paid	\$ 8,196,825	\$ 7,542,428	\$ 7,773,631
Stop loss insurance (net of refunds)	<u>796,368</u>	<u>768,643</u>	<u>31,997</u>
Total benefits	<u>8,993,193</u>	<u>8,311,071</u>	<u>7,805,628</u>
Percent of contributions (net of reciprocity)	76%	86%	96%
Administrative fees			
BeneSys	142,271	122,381	134,045
Blue Cross Blue Shield	<u>468,740</u>	<u>405,215</u>	<u>344,748</u>
Total administrative fees	<u>611,011</u>	<u>527,596</u>	<u>478,793</u>
Professional fees			
Legal	15,001	13,827	23,785
Auditing - financial statements	22,386	21,215	21,925
Auditing - contractors' payrolls	<u>10,468</u>	<u>11,155</u>	<u>7,739</u>
Total professional fees	<u>47,855</u>	<u>46,197</u>	<u>53,449</u>
Other deductions			
Meeting expense	2,289	3,597	1,971
Consulting fees	36,141	2,003	13,177
Fiduciary liability insurance	37,872	25,077	20,791
Postage	15,428	12,443	15,985
Printing	7,786	6,327	7,648
Bank charges	2,430	1,648	9,563
Seminars	-	-	680
ACA mandated reinsurance and PCORI fees	3,745	3,291	3,091
Miscellaneous	<u>9,229</u>	<u>31,061</u>	<u>36,025</u>
Total other deductions	<u>114,920</u>	<u>85,447</u>	<u>108,931</u>
Total deductions	<u>\$ 9,766,979</u>	<u>\$ 8,970,311</u>	<u>\$ 8,446,801</u>
Total non-benefit expenses	<u>\$ 773,786</u>	<u>\$ 659,240</u>	<u>\$ 641,173</u>
Percent of net contributions	<u>7%</u>	<u>7%</u>	<u>8%</u>
Percent of benefits paid	<u>9%</u>	<u>8%</u>	<u>8%</u>

**SHEET METAL WORKERS LOCAL 7, ZONE 1 HEALTH & WELFARE PLAN
HIGHLIGHTS
SCHEDULE OF BENEFITS AND EXPENSE COVERAGE RATIOS
DECEMBER 31, 2014 - 2024**

	<u>Net Assets</u>	<u>Benefits</u>	<u>Coverage Ratio (days)</u>	<u>Total Expenses</u>	<u>Coverage Ratio (days)</u>
12/31/24	\$ 10,253,618	\$ 8,993,193	416	\$ 9,766,979	383
12/31/23	7,745,104	8,311,071	340	8,970,311	315
12/31/22	6,700,606	7,805,628	313	8,446,801	290
12/31/21	6,751,816	6,963,128	354	7,630,390	323
12/31/20	5,767,634	6,866,743	307	7,469,726	282
12/31/19	5,431,017	7,004,183	283	7,627,515	260
12/31/18	5,280,111	6,293,593	306	6,939,097	278
12/31/17	4,561,147	7,628,452	218	7,983,668	209
12/31/16	5,340,649	6,976,979	279	7,392,328	264
12/31/15	5,473,192	6,534,142	306	6,998,238	285
12/31/14	5,129,266	7,025,412	266	7,432,039	252



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INDEPENDENT AUDITOR'S REPORT

To the Trustees of the
Sheet Metal Workers Local 7, Zone 1 Health & Welfare Plan

Opinion

We have audited the financial statements of Sheet Metal Workers Local 7, Zone 1 Health & Welfare Plan, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits (modified cash basis) as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits (modified cash basis) for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits (modified cash basis) of Sheet Metal Workers Local 7, Zone 1 Health & Welfare Plan as of December 31, 2024 and 2023, and the changes in its net assets available for benefits (modified cash basis) for the years then ended, in accordance with the modified cash basis of accounting.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Sheet Metal Workers Local 7, Zone 1 Health & Welfare Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis of Accounting

We draw attention to Note 2 of the financial statements, which describes the basis of accounting. The financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to that matter.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the modified cash basis of accounting; and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of the financial statements that are free from material misstatement, whether due to fraud or error.

Management is also responsible for maintaining a current plan instrument, including all plan amendments, administering the plan, and determining that the plan's transactions that are presented and disclosed in the financial statements are in conformity with the plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if, there is a substantial likelihood that, individually or in the aggregate, they would influence the judgement made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risk of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Sheet Metal Workers Local 7, Zone 1 Health & Welfare Plan's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Sheet Metal Workers Local 7, Zone 1 Health & Welfare Plan's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The highlights, as identified in the table of contents, are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information presented for the purposes of additional analysis. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In our opinion, the information in the accompanying schedules is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

Maney Costeiran PC

October 27, 2025

**SHEET METAL WORKERS LOCAL 7, ZONE 1 HEALTH & WELFARE PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
(MODIFIED CASH BASIS)
DECEMBER 31, 2024 AND 2023**

	<u>2024</u>	<u>2023</u>
ASSETS		
Cash	<u>\$ 10,253,618</u>	<u>\$ 7,745,104</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u><u>\$ 10,253,618</u></u>	<u><u>\$ 7,745,104</u></u>

See notes to financial statements.

**SHEET METAL WORKERS LOCAL 7, ZONE 1 HEALTH & WELFARE PLAN
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
(MODIFIED CASH BASIS)
YEARS ENDED DECEMBER 31, 2024 AND 2023**

	2024	2023
ADDITIONS TO PLAN ASSETS		
Investment income		
Interest and dividends	\$ 300	\$ 4,060
Employer contributions (net of reciprocity of \$211,993 in 2024 and \$139,053 in 2023)	11,345,358	9,271,980
Member self-payments	450,607	359,062
Prescription drug rebates	479,228	379,707
TOTAL ADDITIONS	12,275,493	10,014,809
DEDUCTIONS FROM PLAN ASSETS		
Payments for health claims	8,196,825	7,542,428
Stop-loss insurance premiums (net of refunds of \$159,859 in 2024 and \$25,437 in 2023)	796,368	768,643
Administrative fees	611,011	527,596
Other administrative expense	162,775	131,644
TOTAL DEDUCTIONS	9,766,979	8,970,311
NET INCREASE	2,508,514	1,044,498
NET ASSETS AVAILABLE FOR BENEFITS		
Beginning of year	7,745,104	6,700,606
End of year	\$ 10,253,618	\$ 7,745,104

See notes to financial statements.

**SHEET METAL WORKERS LOCAL 7, ZONE 1 HEALTH & WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS**

NOTE 1 - DESCRIPTION OF THE PLAN

The following brief description of the Sheet Metal Workers Local 7, Zone 1 Health & Welfare Plan is provided for general information purposes only. Participants should refer to the summary plan description and to the plan agreement for complete information.

The Plan was established pursuant to a collective bargaining agreement between the Five Cities Association and the Sheet Metal Workers' International Association, Local Union 7 for the purpose of providing life insurance, survivor income, accidental death and dismemberment, weekly disability, medical, dental and vision benefits for union member/employees and their eligible dependents or survivors and retirees. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). Union members establish eligibility by working 400 hours in any period of nine consecutive months or less and having employer contributions for such work remitted to the Plan. Benefits are also available to salaried administrative employees.

The collective bargaining agreement provides for employers to contribute to the Plan on the basis of participants' hours worked. The hourly contribution rate was \$8.39 and \$8.79 as of May 1, 2023 and 2024, respectively. Members who have exhausted their eligibility credits may continue coverage for up to ten months by paying a monthly fee established by the Trustees. Surviving spouses and retirees continue coverage by paying a reduced monthly fee.

The Plan is self-insured. To protect against catastrophic losses, the Plan has purchased stop-loss insurance coverage with annual retained limits of \$175,000 specific and \$5,000,000 aggregate.

In the event of termination, the Trustees will apply the Plan assets to pay any and all obligations. Any further surplus remaining in the Plan will be used at the discretion of the Trustees to provide benefits for the employees covered at the time of the termination of the agreement to the extent that such Plan assets will provide. None of the surplus is to be distributed to the employers or participants directly.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The books of the Plan are maintained on the modified cash basis of accounting as permitted under provisions of ERISA, and the financial statements have been prepared on that basis. The modified cash basis differs from the accrual basis required by generally accepted accounting principles primarily because employer contributions are recognized as revenue when received rather than when the hours are worked by the members, and expenses are recognized when paid.

Investments are recorded at aggregate fair value based on quoted market prices. The difference between fair value and the cost of investments is reflected as a change in net appreciation (depreciation) in fair value of investments. The realized gain or loss on investments represents the difference between the proceeds received and the cost of investments sold.

The Plan is required to disclose significant concentrations of credit risk regardless of the degree of such risk. The Plan deposits its cash in FDIC insured financial institutions. In the opinion of the Plan's management, cash is subject to minimal credit risk.

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

**SHEET METAL WORKERS LOCAL 7, ZONE 1 HEALTH & WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS**

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Certain expenses of maintaining the Plan are paid by the Plan, unless otherwise paid by the Union or Employers. Expenses that are paid by the Union or Employers are excluded from these financial statements.

The Plan evaluates events and transactions that occur after year end for potential recognition or disclosure in the financial statements. These subsequent events have been considered through October 27, 2025 which is the date the financial statements were available to be issued.

NOTE 3 - TRANSACTIONS WITH PARTIES-IN-INTEREST

Fees paid during the year for legal, accounting, consulting, administrative and other services rendered by parties-in-interest are, in the opinion of the trustees, based on customary and reasonable rates for such services.

The agreement with the plan administrator provides payment for services rendered at a flat rate. Total fees under the arrangement amounted to \$142,271 and \$110,358 in 2024 and 2023, respectively.

NOTE 4 - INCOME TAX STATUS

The Internal Revenue Service has determined that the Plan is qualified and the trust established under the Plan is tax-exempt under the provisions of Section 501(c)(9) of the Internal Revenue Code. The Plan has been amended since receiving the determination letter on December 18, 2003. The Plan administrator and the Plan's tax counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Code. Therefore, they believe that the Plan was qualified and the related trust was tax-exempt as of the financial statement date.

The modified cash basis of accounting requires plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain tax position that more likely than not would not be sustained upon examination by the Internal Revenue Service. The plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2024, there are no uncertain tax positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

NOTE 5 - BENEFIT OBLIGATIONS

The Plan's benefit obligation is comprised of three components: 1) benefits and claims currently payable, 2) postretirement benefits, and 3) other plan benefits reported at present value of estimated amounts. A summary of each component follows.

Benefits and Claims Currently Payable

This component included amounts currently payable for claims or benefits incurred prior to the Plan's year end.

**SHEET METAL WORKERS LOCAL 7, ZONE 1 HEALTH & WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS**

NOTE 5 - BENEFIT OBLIGATIONS (continued)

Postretirement Benefits

The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered to December 31, reduced by the actuarial present value of contributions expected to be received in the future from current participants. Postretirement benefits include future benefits expected to be paid to or for 1) currently retired or terminated employees and their beneficiaries and dependents, and 2) active employees and their beneficiaries and dependents after retirement from service with the participating employers. Before an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service in the plan rendered to valuation date. The postretirement benefit obligation represents the amount that is to be funded by contributions from the Plan's participating employees and from existing plan assets.

The actuarial present value of the expected postretirement benefit obligation is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money through discounts for interests and the probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment.

Other Plan Benefits

Plan obligations at December 31 for health claims incurred by active participants but not reported at that date and for accumulated eligibility of participants are estimated by the Plan's actuary in accordance with accepted actuarial principles. Such estimated amounts are reported in the accompanying statements of the Plan's benefit obligations at present value, where applicable, based on a 5.50% and 4.75% discount rate for the years ended December 31, 2024 and 2023, respectively. Health claims incurred by retired participants but not reported at the year-end are included in the postretirement benefit obligation.

The following tables present the components of the Plan's benefit obligations and related changes in the Plan's benefit obligation.

	December 31,	
	2024	2023
Postretirement benefit obligations		
Current retirees	\$ 36,070,000	\$ 39,350,000
Other participants fully eligible for benefits	6,470,000	5,720,000
Other participants not yet fully eligible for benefits	34,040,000	35,500,000
	76,580,000	80,570,000
Other obligations for benefit coverage at present value of estimated amounts		
Claims incurred but not reported	424,000	661,000
Accumulated eligibility credits	2,693,000	2,232,000
Total benefit obligations	\$ 79,697,000	\$ 83,463,000

**SHEET METAL WORKERS LOCAL 7, ZONE 1 HEALTH & WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS**

NOTE 5 - BENEFIT OBLIGATIONS (continued)

Other Plan Benefits (continued)

	2024	2023
Benefit obligations, beginning of year	\$ 83,463,000	\$ 62,576,000
Benefits earned and other changes	3,820,000	2,200,000
Actuarial experience loss	-	3,010,000
Changes in actuarial assumptions	(7,810,000)	15,300,000
Change in claims incurred but not reported and accumulated eligibility credits	224,000	377,000
Benefit obligations, end of year	\$ 79,697,000	\$ 83,463,000
Weighted-average discount rate	5.50%	4.75%

The funding of the above benefit obligations is not covered by the contribution rate provided by the current bargaining agreement. It is expected that benefit obligations will be funded through future contribution rates.

For measurement purposes, an 8.00% annual rate of increase in the per-capita cost of covered health care benefits was assumed for 2024; the rate was assumed to decrease to 4.50% for 2039 and remain at that level thereafter. A 7.50% annual rate of increase was assumed for 2023; the rate was assumed to decrease to 4.50% for 2036 and remain at that level thereafter.

The following were other significant assumptions used in the valuations as of December 31, 2024 and 2023.

Assumed retirement age:	2024	2023
	25% at age 55	25% at age 55
	15% at age 56	15% at age 56
	15% at age 57	15% at age 57
	15% at age 58	15% at age 58
	15% at age 59	15% at age 59
	15% at age 60	15% at age 60
	15% at age 61	15% at age 61
	100% at age 62	100% at age 62

Postretirement mortality rates: 2024: 95% of Pri-2012 Headcount-weighted Blue Collar Healthy Retiree Mortality Table, projected generationally from 2012 using 75% of Scale MP-2020; [2023: 95% of Pri-2012 Headcount-weighted Blue Collar Healthy Retiree Mortality Table, projected generationally from 2012 using 75% of Scale MP-2020]

**SHEET METAL WORKERS LOCAL 7, ZONE 1 HEALTH & WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS**

NOTE 5 - BENEFIT OBLIGATIONS (continued)

Other Plan Benefits (continued)

The weighted average health care cost-trend rate assumption has a significant effect on the benefit obligations. If the assumed rates increased by one percentage point, it would increase the obligations by approximately \$13,765,000 and \$15,483,000 as of December 31, 2024 and 2023, respectively.

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of postretirement benefits.

During the years ended December 31, 2024 and 2023, the gross benefits paid and expected to be paid, including prescription drug benefits were \$8,196,825 and \$7,542,428, respectively.

Monthly retiree contributions:

	December 31, 2024	December 31, 2023
Single retiree age 55 - 57	\$ 316	\$ 316
Retiree age 55 - 57, spouse not on Medicare	633	633
Retiree age 55 - 57, spouse on Medicare	363	363
Single retiree age 58 - 64	123	123
Retiree age 58 - 64, spouse not on Medicare	248	248
Retiree age 58 - 64, spouse on Medicare	172	172
Single retiree over age 65	50	50
Retiree on Medicare, spouse not on Medicare	172	172
Retiree and spouse over age 65	97	97
Widow over age 65	50	50
Widow under age 65	123	123
	December 31, 2024	December 31, 2023
Estimated current cost of providing post retirement benefits	\$ 2,554,000	\$ 2,399,000

**SHEET METAL WORKERS LOCAL 7, ZONE 1 HEALTH & WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS**

NOTE 5 - BENEFIT OBLIGATIONS (continued)

Other Plan Benefits (continued)

Per capita costs:

2024						
Age	Medical		Non-Medicare Prescription Drug		Medical & Prescription Drug	
	Retiree and Spouse		Retiree and Spouse		Retiree and Spouse	
	Male	Female	Male	Female	Male	Female
55	\$ 8,641	\$ 8,777	\$ 1,432	\$ 1,455		
60	9,949	9,515	1,649	1,577		
64	12,091	10,330	2,004	1,712		
65					\$ 3,589	\$ 2,981
70					4,031	3,335
75					4,453	3,506
2023						
Age	Medical		Non-Medicare Prescription Drug		Medical & Prescription Drug	
	Retiree and Spouse		Retiree and Spouse		Retiree and Spouse	
	Male	Female	Male	Female	Male	Female
55	\$ 8,038	\$ 8,165	\$ 1,332	\$ 1,353		
60	9,255	8,851	1,534	1,467		
64	11,247	9,609	1,864	1,592		
65					\$ 3,190	\$ 2,650
70					3,583	2,964
75					3,958	3,116

Significant changes in actuarial assumptions reflected in the 2024 valuation include:

- Discount rate increased from 4.75% to 5.50%.
- Valuation year per capita health costs were updated
- Future trend rates on health care were updated.

NOTE 6 - RISKS AND UNCERTAINTIES

The Plan invests, from time to time, in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statement of net assets available for benefits.

The actuarial present value of benefit obligations is reported based on certain assumptions pertaining to interest rates, health care inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

**SHEET METAL WORKERS LOCAL 7, ZONE 1 HEALTH & WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS**

NOTE 7 - SUPPLEMENTAL SCHEDULE

The Plan does not consider cash in bank to be an asset held for investment purposes. Thus, no supplemental schedule of assets held for investment purposes at end of year, as required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, is required.

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210 - 0110
1210 - 0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

- A** This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- B** This return/report is: a single-employer plan a DFE (specify) _____
 the first return/report the final return/report
 an amended return/report a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here
- D** Check box if filing under: Form 5558 automatic extension the DFVC program
 special extension (enter description)
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here

Part II Basic Plan Information - enter all requested information

1a Name of plan SHEET METAL WORKERS LOCAL 7, ZONE 1 HEALTH & WELFARE PLAN	1b Three-digit plan number (PN) ▶	501
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) SHEET METAL WORKERS, LOCAL 7, ZONE 1 HEALTH & WELFARE 700 TOWER DR, STE 300 TROY MI 48098-2808	1c Effective date of plan 01/01/1954	2b Employer Identification Number (EIN) 38-6099712
	2c Plan Sponsor's telephone number (248) 813-9800	2d Business code (see instructions) 813930

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		3/3/2026	ERIC FARRINGTON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2024)
v. 240311

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor BENESYS 700 TOWER DR, STE 300 TROY MI 48099-1218	3b Administrator's EIN 38-2383171 3c Administrator's telephone number (248) 822-4200
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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
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5 Total number of participants at the beginning of the plan year	5	933
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)	622
a (2) Total number of active participants at the end of the plan year	6a(2)	674
b Retired or separated participants receiving benefits	6b	311
c Other retired or separated participants entitled to future benefits	6c	
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	985
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f Total. Add lines 6d and 6e	6f	
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)	
(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	40

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

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

9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
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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) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> DCG (Individual Plan Information) - Number Attached _____ (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information - Small Plan) (3) <input checked="" type="checkbox"/> A (Insurance Information) - Number Attached <u>2</u> (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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