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

2025

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2025 or fiscal plan year beginning 01/01/1923 and ending 01/01/2025

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

B This return/report is:
- [X] 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
- [X] 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
PROBUSGORMANY81RESUBM

1b Three-digit plan number (PN) ▶ 072

1c Effective date of plan 01/01/1981

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)

GURUPRASAD SRIHARI

PROBUS TECHNICAL SERVICES INC

GURUPRASAD SRIHARI

836, 16TH MAIN ROAD BANASHANKARI 2 STAGE
BANGALORE, KARNATAKA 560070 IN

132 SHERMAN RD
ENFIELD, CT 06082

2b Employer Identification Number (EIN)
45-6577522

2c Plan Sponsor's telephone number
+919482912724

2d Business code (see instructions)
532990

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	04/01/2026	GURUPRASAD SRIHARI
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	04/01/2026	GURUPRASAD SRIHARI
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

3b Administrator's EIN

3c Administrator's telephone number

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

a Sponsor's name

4b EIN

c Plan Name

4d PN

5	Total number of participants at the beginning of the plan year	**5**	8
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)**	8
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	8
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	8
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	4
f	Total. Add lines **6d** and **6e**.	**6f**	12
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	4
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	4
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 Characteristic Codes in the instructions:

3B 3D

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

4A

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached _____
- **(4)** [X] **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 2025 Form M-1 annual report. If the plan was not required to file the 2025 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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
PROBUSGORMANY81RESUBM

B Three-digit plan number (PN) ▶ 072

C Plan sponsor's name as shown on line 2a of Form 5500
GURUPRASAD SRIHARI

D Employer Identification Number (EIN)
45-6577522

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
GAILILEE

(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
27-4300000	52211	S87546	10	01/01/1950	01/01/1980

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
25000	7000

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

GURUPRASAD SRIHARI
210 W SIXTH STREET
APT 302
ERIE, PA 16507

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3200	200	TAX PROFESSIONAL AS AUTHORIZED AND AS LEGAL AFFAIRS	2

(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	15000
5	Current value of plan's interest under this contract in separate accounts at year end	5	14000

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ ANCESTORAL DEEMED GRANDMOTHER'S CHITRANGADA BAI SILVER PROPERTY., RIGHTUL SOLE AS SELF OTHER RIGHTS

b	Premiums paid to carrier	6b	1400
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	600

Specify nature of costs ▶ NEGOTIATION WITH GOVERMENT OF INDIA STATE KARNATAKA, AND US COUNTRRPART PA STATE AND FEDERAL AFFAIRS

e Type of contract: (1) [X] individual policies (2) [ ] group deferred annuity

(3) [X] other (specify) ▶ US GOVMNT OBL8GATORY, AND A PERSPECTIVE OF COUNTRY INDIA ANCESTRAL PROPERTY, RIGHTFUL HOLDINGS TITLE

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) [X] deposit administration (2) [ ] immediate participation guarantee

(3) [ ] guaranteed investment (4) [ ] other ▶

b	Balance at the end of the previous year			7b	25000
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)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	25000
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	1000		
	(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)	1000
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	24000

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [X] Dental
- **c** [X] Vision
- **d** [X] 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 [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(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 [X] 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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/1923 and ending 01/01/2025

A Name of plan
PROBUSGORMANY81RESUBM

B Three-digit plan number (PN) ▶ 072

C Plan sponsor's name as shown on line 2a of Form 5500
GURUPRASAD SRIHARI

D Employer Identification Number (EIN)
45-6577522

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

(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

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid

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		
	(c) Amount	**(d)** Purpose	**(e)** Organization code

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** ☐ 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 ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(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.**

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

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/1923 and ending 01/01/2025

A Name of plan
PROBUSGORMANY81RESUBM

B Three-digit plan number (PN) ▶ 072

C Plan sponsor's name as shown on line 2a of Form 5500
GURUPRASAD SRIHARI

D Employer Identification Number (EIN)
27-6769793

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
MARTIN BLAKE

(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
27-6769793	53299	6 O71 I 239960	10	01/01/2023	12/31/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
3500	600

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. Specify nature of costs ▶	6d	

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] 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 [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(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 C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2025** **This Form is Open to Public Inspection.**

For calendar plan year 2025 or fiscal plan year beginning 01/01/1923 and ending 01/01/2025

A Name of plan
PROBUSGORMANY81RESUBM

B Three-digit plan number (PN) ▶ 072

C Plan sponsor's name as shown on line 2a of Form 5500
GURUPRASAD SRIHARI

D Employer Identification Number (EIN)
45-6577522

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

GURUPRASAD SRIHARI
836, 16TH MAIN ROAD, BSK 2 STAGE
BENGALURU, KARNATAKA 560070 IN

38-3269858

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

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

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

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

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

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

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

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

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

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

(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)

HEALTH SAGE CONSULTING INC

50 CIR SW
PARK CITY, UTAH US

27-3959113

(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?
40	OFFICIAL	12000	Yes [X] No [ ]	Yes [X] No [ ]	2000	Yes [X] No [ ]

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

(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?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

(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?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

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
HEALTHCARE SAGE CONSULTING INC	40	

(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.
GURUPRASAD SRIHARI 210 W SIXTH STREET APT 302 ERIE, PA 16507 US 27-3959113	SERVICES AS US CONGRESS, LEGAL AMENDMENTS RILED TO SENATE COUNCIL, STATE LAWS AS FORMULA STATUS PARED INDEMNITY ENTIRETY. PERSONAL CRAN S STAN CE APPROVED

(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

(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

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 DCG (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Individual Plan Information

This schedule is required to be filed under section 103 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.**

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

Part I DCG Information

A Name of DCG
PROBUSGORMANY81RESUBM

B Three-digit plan number (PN) ▶ 072

C DCG Sponsor's Name (enter here only if different from Name of DCG)
GURUPRASAD SRIHARI

D Employer Identification Number (EIN) for DCG
45-6577522

Part II Individual Schedule DCG Information. Complete a separate Schedule for each individual defined contribution pension plan.

E This Schedule DCG is for: [X] a single-employer plan [ ] a collectively-bargained plan

F This Schedule DCG is: [X] the first Schedule [ ] the final Schedule [ ] an amended Schedule

Part III Basic Individual Plan Information

1a Name of plan
PROBUSGORMANY50

1b Three-digit plan number (PN) 072

1c Effective date of plan 01/01/1950

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)
GURUPRASAD SRIHARI
FRANCIS P GORMAN ESTATE
FRANCIS P GORMAN
836, 16TH MAIN ROAD BANASHANKARI 2 STAGE
BENGALURU, KARNATAKA 560070 IN
132 SHERMAN ROAD
ENFIELD, CT 06082

2b Employer Identification Number (EIN) 45-6577522

2c Plan sponsor's telephone number +919482912724

2d Business code 531390

3 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 Plan sponsor's name
c Plan Name

3b EIN

3d PN

4a Plan administrator's name and address
FRANCIS P GORMAN ESTATE
FRANCIS P GORMAN
142 SHERMAN ROAD
ENFIELD, CT 06082

4b EIN 45-6577522

4c Administrator's telephone number +919482912724

5a	Total number of participants at the beginning of the plan year	**5a**	6
b	Total number of participants as of the end of the plan year	**5b**	6
c(1)	Total number of active participants at the beginning of the plan year	**5c(1)**	4
c(2)	Total number of active participants at the end of the plan year	**5c(2)**	4
d(1)	Number of participants with account balances as of the beginning of the plan year	**5d(1)**	4
d(2)	Number of participants with account balances as of the end of the plan year	**5d(2)**	4
e	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**5e**	

Part IV Financial Information

6	Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a	Total plan assets	6a	40000	45000
	(1) Participant loans	6a(1)		
b	Total plan liabilities	6b	14000	13500
c	Net Assets (subtract line 6b from line 6a)	6c	26000	31500

7a	Contributions received or receivable in cash from		Amount
	(1) Employers	7a(1)	4000
	(2) Participants	7a(2)	1000
	(3) Others (including rollovers)	7a(3)	0
b	Noncash contributions	7b	1500
c	Total Contributions (add lines 7a(1)-(3) and line 7(b))	7c	6500
d	Other income (loss)	7d	6000
e	Total Income (add lines 7c and 7d)	7e	12500
f	Benefit payment and payments to provide benefits	7f	2000
g	Corrective distributions (see instructions)	7g	
h	Certain deemed distributions of participant loans (see instructions)	7h	
i	Administrative service provider's expense (salaries, fees, commissions)	7i	400
j	Other expenses	7j	
k	Total expenses (add lines 7f, 7g, 7h, 7i, and 7j)	7k	2400
l	Net income (loss) (subtract line 7k from line 7e)	7l	10100
m	Transfers of assets		
	(1) To this plan	7m(1)	3000
	(2) From this plan	7m(2)	

Part V Plan Characteristic Codes

8 Enter the applicable two-character feature codes from the List of Plan Characteristic Codes in the instructions.

3D

Part VI Compliance Questions

			Yes	No	Amount
9a	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.)	9a		X	
b	Were there any nonexempt transactions with any party-in-interest?	9b		X	
c	Has the plan failed to provide any benefit when due under the plan?	9c		X	
d	Was the plan covered by a fidelity bond?	9d	X		20000
e	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	9e		X	

10 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)

10a Name of plan(s)	10b EIN(s)	10c PN(s)

11 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code? ☐ Yes ☒ No

12a Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules? ☒ Yes ☐ No

12b If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2)?

☒ Design-based safe harbor method ☐ "Prior year" ADP test ☐ "Current year" ADP test ☐ N/A

13 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter ___/___/_____ (MM/DD/YYYY) and the Opinion Letter serial number _____.

Part VII Accountant Opinion Information for Participating Plans

14 Is the plan required to attach a report of an independent qualified public accountant (IQPA)? (See instructions on eligibility and condition for waiver of the annual examination and report of an IQPA under 29 CFR 2520.104-46):

☐ Yes ☒ No

Complete lines 14a through 14c if you checked "YES" and the report of an IQPA for the plan is required to be attached to this Schedule DCG.

a The opinion reflected in the attached report of an IQPA 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: **(2)** EIN:

Landowner Report Summary

Notification #2302485

General Details

LOR Reporting Year:
2023

Town, Township, or Plantation:
T4 R7 WELS

County:
Penobscot

Landowner Contact

Name: Guruprasad Srihari

Company Name: Probus Services inc

Physical Address: 210 W sixth street, Apt 302, Erie, Pennsylvania 16507

Mailing Address: 210 W sixth street, Apt 302, Erie, Pennsylvania 16507

- This property **WAS** harvested during this year.
- This harvest **WAS** completed this year.
- There **WERE** non-harvest activities during this reporting year.

Method of Payment or Type of Sale:
Landowner did not cut the trees but received payment for them

Involvement Details

- A Written Management Plan **WAS** developed for this property.
- A Maine Licensed Forester **DID** supervise this harvest.

Licensed Forester / License Number:
Guruprasad Srihari / FI9844025722

Operator/Harvester Contact

Name: Guruprasad Srihari

Company Name: Probus Services inc

Physical Address: 210 W sixth street, Apt 302, Erie, Pennsylvania 16507

Mailing Address: 210 W sixth street, Apt 302, Erie, Pennsylvania 16507

Broker(s)/Exporter(s)

- Forest products **WERE NOT** exported outside of Maine or sold to a broker for export.

Activity Details

Harvest Information

Partial cut:
0.5 acres

Initial/Intermediate Shelterwood Harvest:
0.5 acres

Final/Overstory Removal Shelterwood Harvest:
1 acres

Clear Cut Harvest(s):

1. 1 acres

Change of Land Use

0.5 acres

Non-Harvest Information

Herbicide Treatment:

Site Preparation:
2 acres

Release Acres:
1 acres

Non-Commercial Thinning:
0.4 acres

Tree Planting:

1. : 1 acres
2. : 1 acres

Additional Information:
Tree proximity to water, soil conditions addressed

Stumpage Details

Stumpage is being reported using **ACTUAL** prices.

Standard Products

Product Type	Species/Group	Volume	Stumpage Price
Veneer	Red Oak	240.00 board feet	$6500.00 per MBF (thousand board feet)
Veneer	Red/White Maple	10000.00 board feet	$4600.00 per MBF (thousand board feet)
Sawlogs	Other Softwood	900.00 board feet	$3200.00 per MBF (thousand board feet)
Sawlogs	Ash	1200.00 board feet	$3200.00 per MBF (thousand board feet)

Palletwood	Hardwood	2500.00 board feet	$8500.00 per MBF (thousand board feet)
Palletwood	Softwood	3200.00 green tons	$2000.00 per green ton
Studwood	Cedar	4600.00 green tons	$14500.00 per green ton
Studwood	Beech	2600.00 cords	$8500.00 per cord
Boltwood	Aspen/Poplar	2100.00 board feet	$2600.00 per MBF (thousand board feet)
Pulpwood	White Pine	1500.00 green tons	$600.00 per green ton
Firewood	Softwood	8000.00 green tons	$1500.00 per green ton
Firewood	Hardwood	6000.00 cords	$2100.00 per cord
Biomass	Mixed Softwood/Hardwood	5600.00 green tons	$1100.00 per green ton
Biomass	Mixed Softwood/Hardwood	560.00 mlbs	$500.00 per MLB (thousand pounds)

Specialty Products

Product Type	Species/Group	Units Harvested/Sold	Stumpage Price
	Red Pine	2100.00 cords	$7500.00 per cord
	Beech	1250.00 green tons	$1200.00 per green ton
	Other Hardwood	5600.00 board feet	$750.00 per MBF (thousand board feet)
	Hemlock	7000.00 mlbs	$3100.00 per MLB (thousand pounds)

INFOSYS CENTRAL LABORATORY

DEPARTMENT OF BIOCHEMISTRY

BANGALORE MEDICAL COLLEGE & RESEARCH INSTITUTE

Victoria Hospital Campus, K.R. Road, Fort

Bengaluru,Karnataka India

Patient Name	: MR. GURU PRASAD	Bill No	: 1757643
Age/Sex	: 50 Yrs / Male	Patient ID	: 437379
Phone No	: 123	Collected On	: 02-06-25 02:17
Doctor	: Dr. VICTORIA	Reported On	: 03-06-25 11:26

TEST NAME	RESULTS	UNITS	NORMAL RANGE	SA
	BIO-CHEMISTRY			
FBS: FASTING BLOOD SUGAR				
FBS: FASTING BLOOD SUGAR	90.2	mg/dL	74 - 109	
BIOCHEMISTRY Verified By			BIOCHEMISTRY Certified By	
PPBS: POST PRANDIAL BLOOD SUGAR				
PPBS: POST PRANDIAL BLOOD SUGAR	123.8	mg/dL	< 140	
BIOCHEMISTRY Verified By			BIOCHEMISTRY Certified By	
HBA1C				
HBA1C	6.0	%	4.8 - 5.9	
BIOCHEMISTRY Certified By			BIOCHEMISTRY Certified By	
RENAL FUNCTION TEST (RFT)				
SERUM UREA	37	mg/dL	16.6 - 48.5	
SERUM CREATININE	1.12	mg/dL	Males - 0.7 - 1.2 Females - 0.5 - 0.9	
BIOCHEMISTRY Certified By			BIOCHEMISTRY Certified By	
SERUM ELECTROLYTES				
SODIUM	139	mmol/L	136 - 145	

INFOSYS CENTRAL LABORATORY

DEPARTMENT OF BIOCHEMISTRY

BANGALORE MEDICAL COLLEGE & RESEARCH INSTITUTE

Victoria Hospital Campus, K.R. Road, Fort

Bangalore,Karnataka,India

Patient Name	: Mr. GIRISH PRASAD	Bill No	: 1753649
Age/Sex	: 38 Yrs / Male	Patient ID	: 457379
Phone No	: 123	Collected On	: 22-04-25 10:17 PM
Doctor	: Dr. VICTORIA	Reported On	: 22-04-25 11:25 AM

TEST NAME	RESULTS	UNITS	NORMAL RANGE	SAMPLE
Verified By			Certified By	
LIVER PROFILE				
[illegible]	224	mg/dL	< 230	
[illegible]	166.4	mg/dL	[illegible]	
[illegible]	48	mg/dL	[illegible]	
[illegible]	36	mg/dL		
[illegible]	142	mg/dL	< 200	
Verified By			Certified By	

*** End Of Report ***

INFOSYS CENTRAL LABORATORY

DEPARTMENT OF BIOCHEMISTRY

BANGALORE MEDICAL COLLEGE & RESEARCH INSTITUTE

Victoria Hospital Campus, K.R. Road, Fort

Bengaluru,Karnataka India

Patient Name	: MR. GURU PRASAD	Bill No	: 1757643
Age/Sex	: 50 Yrs / Male	Patient ID	: 437379
Phone No	: 123	Collected On	: 02-06-25 02:17
Doctor	: Dr. VICTORIA	Reported On	: 03-06-25 11:26

TEST NAME	RESULTS	UNITS	NORMAL RANGE
	BIO-CHEMISTRY		
FBS: FASTING BLOOD SUGAR			
FBS: FASTING BLOOD SUGAR	90.2	mg/dL	74 - 109
BIOCHEMISTRY Verified By			BIOCHEMISTRY Certified By
PPBS: POST PRANDIAL BLOOD SUGAR			
PPBS: POST PRANDIAL BLOOD SUGAR	123.8	mg/dL	< 140
BIOCHEMISTRY Verified By			BIOCHEMISTRY Certified By
HBA1C			
HBA1C	6.0	%	4.8 - 5.9
BIOCHEMISTRY Verified By			BIOCHEMISTRY Certified By
RENAL FUNCTION TEST (RFT)			
SERUM UREA	37	mg/dL	16.6 - 48.5
SERUM CREATININE	1.12	mg/dL	Males - 0.7 - 1.2 Females - 0.5 - 0.9
BIOCHEMISTRY Verified By			BIOCHEMISTRY Certified By
SERUM ELECTROLYTES			
SODIUM	139	mmol/L	136 - 145

INFOSYS CENTRAL LABORATORY

DEPARTMENT OF BIOCHEMISTRY
BANGALORE MEDICAL COLLEGE & RESEARCH INSTITUTE
Victoria Hospital Campus, K.R. Road, Fort
Bengaluru,Karnataka,India

ient Name	: MR. GURU PRASAD	Bill No	: 1757643
e/Sex	: 58 Yrs / Male	Patient ID	: 437379
ne No	: 123	Collected On	: 02-06-25 02:37 PM
ctor	: Dr. VICTORIA	Reported On	: 03-06-25 11:28 AM

TEST NAME	RESULTS	UNITS	NORMAL RANGE	SAMPLE
SERUM ELECTROLYTES				
POTASSIUM	5.18	mmol/L	3.5 - 5.1	
CHLORIDE	103.0	mmol/L	98 - 107	

BIOCHEMISTRY
Verified By

BIOCHEMISTRY
Certified By

LIVER FUNCTION TEST				
TOTAL BILIRUBIN	0.50	mg/dL	up to 1.2	SERUM
DIRECT BILIRUBIN	0.15	mg/dL	<= 0.30	
INDIRECT BILIRUBIN	0.2	mg/dL	0.20 - 0.80	
TOTAL PROTEIN	7.5	g/dL	6.6 - 8.7	
ALBUMIN	4.8	g/dL	3.56 - 4.61	
GLOBULIN	2.7	g/dL	2.0 - 3.5	
A/G RATIO	1.8		1.5 : 1 to 2.5 : 1	
ALP	77	U/L	Males - 40 - 129 Females - 35 - 105	
SGOT/AST	18	U/L	Males - upto 46 Females - upto 32	
SGPT/ALT	12	U/L	Males - upto 41 Females - upto 33	

INFOSYS CENTRAL LABORATORY

DEPARTMENT OF PATHOLOGY

BANGALORE MEDICAL COLLEGE & RESEARCH INSTITUTE

Victoria Hospital Campus, K.R. Road, Fort

Bengaluru,Karnataka,India

Patient Name	: MR. GURU PRASAD	Bill No	: 1757643
Age/Sex	: 58 Yrs / Male	Patient ID	: 437379
Ward/Bed No	: 123	Collected On	: 02-06-25 02:17 PM
Doctor	: Dr. VICTORIA	Reported On	: 03-06-25 11:26 AM

TEST NAME	RESULTS	UNITS	NORMAL RANGE	SAMPLE
		HAEMATOLOGY		
MEAN PLATELET VOLUME	9.0	fl	6.6 - 10.2	

Dr. PHILOMIN
Verified By

Dr. PHILOMIN
Certified By

*** End Of Report ***

INFOSYS CENTRAL LABORATORY

DEPARTMENT OF PATHOLOGY

BANGALORE MEDICAL COLLEGE & RESEARCH INSTITUTE

Victoria Hospital Campus, K.R. Road, Fort

Bengaluru,Karnataka,India

Patient Name	: MR. GURU PRASAD	BAR No	: 1757643
Age/Sex	: 59 Yrs / Male	Patient ID	: 437379
Phone No	: 123	Collected On	: 02-06-25 02:17 PM
Doctor	: Dr. VICTORIA	Reported On	: 03-06-25 11:25 AM

TEST NAME	RESULTS	UNITS	NORMAL RANGE	SAMPLE
HAEMATOLOGY				
COMPLETE BLOOD COUNT				
HAEMOGLOBIN PERCENTAGE	14.8	g/dL	13.0 - 17.0	
PACKED CELL VOLUME	44.5	%	40 - 50	
RED BLOOD CELL COUNT	4.97	million/cumm	4.5 - 5.5	
MEAN CORPUSCULAR VOLUME	91.5	fl	83 - 101	
MEAN CORPUSCULAR HAEMOGLOBIN	30.5	pg	27 - 32	
MEAN CORPUSCULAR HB CONCENTRATION	33.4	g/dL	32 - 36	
RED CELL DISTRIBUTION WIDTH	14.1	%	11.6 - 14	
TOTAL WBC COUNT	6900	cells/cumm	4000 - 11000	
NEUTROPHILS	45.1	%	35 - 77	
LYMPHOCYTES	40.6	%	21 - 44	
MONOCYTES	8.8	%	3 - 9	
EOSINOPHILS	3.7	%	0 - 3	
BASOPHILS	1.8	%	0 - 2	
ABSOLUTE NEUTROPHIL COUNT	2790	cells/cumm	2000 - 7000	
ABSOLUTE LYMPHOCYTE COUNT	2490	cells/cumm	1000 - 3000	
ABSOLUTE MONOCYTE COUNT	600	cells/cumm	200 - 1000	
ABSOLUTE EOSINOPHIL COUNT	260	cells/cumm	20 - 500	
ABSOLUTE BASOPHIL COUNT	100	cells/cumm	20 - 100	
PLATELET COUNT	1.05	lakhs/cumm	1.5 - 4.5	

A. To be completed by Hearing Office

(Claimant and Social Security Number)	(Wage Earner and Social Security Number) (Leave blank if same as claimant)	The last time we brought your case up-to-date was:

B. To be completed by the Claimant

PLEASE PRINT

PLEASE LIST BELOW THE PRESCRIPTION MEDICATION WHICH YOU ARE PRESENTLY TAKING. IF THE NAME OF THE MEDICATION IS NOT SHOWN ON THE PRESCRIPTION CONTAINER, YOU MAY VERIFY THE NAME WITH YOUR PHARMACIST.

NAME OF MEDICATION & DOSAGE	DATE FIRST PRESCRIBED	DAILY AMOUNT TAKEN	REASON FOR MEDICATION	NAME OF PHYSICIAN

PLEASE LIST BELOW THE NONPRESCRIPTION MEDICATION YOU ARE TAKING AND THE REASONS YOU TAKE THEM.

One timw medical test cardiology 2D echo and ECG

PATIENT NAME	GURUPRASAD SRIHARI	DATE	02-06-2025
AGE/SEX	58 YRS, MALE	PERFORMED BY	IN BS/YD
ECHO ID	20207	REF BY	CARDIOLOGY

MEASUREMENTS AND CALCULATIONS (2D, M-MODE AND DOPPLER)

LVIDd	43	cms
LVIDs	28	cms
IVSd	09	cms
IVSs	12	cms
LVPWd	09	cms
LVPWs	12	cms
RVIDd	15	cms
AO	30	cms
LA	30	cms
EDV	84	ml
ESV	30	ml
EF	63	%

ADDITIONALS		

MITRAL VALVE		
E Vmax	-	m/sec
A Vmax	-	m/sec
DecT	-	ms
IVRT	-	ms
E/A RATIO	-	
AORTIC VALVE		
AV Vmax	-	m/sec
AV PGmax	-	mmHg
PULMONARY VALVE		
PV Vmax	-	m/sec
PV PGmax	-	mmHg
TRICUSPID VALVE		
TR PG max	25	mmHg
PASP	30	mmHg

FINAL ECHOCARDIOGRAPHIC IMPRESSION

- SCLEROTIC AORTIC VALVE, TRIVIAL AR
- MILD MR
- NO RESTING REGIONAL WALL MOTION ABNORMALITIES
- NORMAL LV SYSTOLIC FUNCTION, LVEF:63%
- NO PERICARDIAL EFFUSION/CLOT/VEGETATION

***SUB-OPTIMAL STUDY ***

** KINDLY CORRELATE CLINICALLY **

DR. M. DIVYAPRAKASH
PROFESSOR AND HEAD, DEPT. OF CARDIOLOGY (UNIT I)
BMC&RI-SSH

PATIENT NAME	GURUPRASAD SRIHARI	PERFORMED BY	IN BS/YD
AGE/SEX	58 YRS, MALE	REF BY	CARDIOLOGY
ECHO ID	20207		

2D AND DOPPLER FINDINGS

RHYTHM	SINUS
SITUS	SOLITUS
SYSTEMIC AND PULMONARY VENOUS DRAINAGE	NORMAL
MITRAL VALVE	NORMAL
AORTIC VALVE	TRILEAFLETS, SCLEROTIC
TRICUSPID VALVE	NORMAL
PULMONARY VALVE	NORMAL
INTER-ATRIAL SEPTUM	INTACT
INTER-VENTRICULAR SEPTUM	INTACT
RIGHT ATRIUM	NORMAL
RIGHT VENTRICLE	NORMAL
LEFT ATRIUM	NORMAL
LEFT VENTRICLE	NORMAL IN SIZE NO RESTING RWMA NORMAL SYSTOLIC FUNCTION
AORTA	NORMAL
PULMONARY ARTERY	NORMAL
PERICARDIUM	NO EFFUSION
DOPLER STUDY	TRIVIAL AR, TR & GRADE I MR