# 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 02/01/2025 and ending 01/31/2026

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

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

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

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

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

## Part II Basic Plan Information—enter all requested information

**1a** Name of plan
RESTAURANT EQUIPMENT COMPANY OF SAVANNAH EMPLOYEE BENEFIT PLAN

**1b** Three-digit plan number (PN) ▶ 501

**1c** Effective date of plan 02/01/2024

**2a** Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
RESTAURANT EQUIPMENT COMPANY OF SAVANNAH

PO BOX 22354
SAVANNAH, GA 31403

**2b** Employer Identification Number (EIN)
58-1107870

**2c** Plan Sponsor's telephone number
912-236-7181

**2d** Business code (see instructions)
423400

**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. | 03/30/2026 | JEFFREY CAREY |
| | **Signature of plan administrator** | Date | Enter name of individual signing as plan administrator |
| **SIGN HERE** | Filed with authorized/valid electronic signature. | 03/30/2026 | JEFFREY CAREY |
| | **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:<br>**a** Sponsor's name<br>**c** Plan Name | **4b** EIN<br>**4d** PN | |
| **5** Total number of participants at the beginning of the plan year | **5** | 13 |
| **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)** | 13 |
| **a(2)** Total number of active participants at the end of the plan year | **6a(2)** | 4 |
| **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** | 4 |
| **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)** | |
| **g(2)** Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) | **6g(2)** | |
| **h** Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested | **6h** | |
| **7** Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | **7** | |

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

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

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

**a Pension Schedules**

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

**b General Schedules**

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

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

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

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

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

**11c** Enter the Receipt Confirmation Code for the 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 02/01/2025 and ending 01/31/2026

**A** Name of plan
RESTAURANT EQUIPMENT COMPANY OF SAVANNAH EMPLOYEE BENEFIT PLAN

**B** Three-digit plan number (PN) ▶ 501

**C** Plan sponsor's name as shown on line 2a of Form 5500
RESTAURANT EQUIPMENT COMPANY OF SAVANNAH

**D** Employer Identification Number (EIN)
58-1107870

**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
ADREM ADMINISTRATORS LLC

| (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 |
| 87-2258484 | 00000 | UT301275 | 4 | 02/01/2025 | 01/31/2026 |

**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 |
|---|---|
| 2650 | 0 |

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

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

EBENCONCEPTS COMPANY
3150 NORTH ELM
STE 201
GREENSBORO, NC 27408

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---|---|---|
| | (c) Amount | (d) Purpose | |
| 1855 | | | 3 |

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

BROKERS HOLDING GROUP
455 ST ANDREW RD
STE E-1
COLUMBIA, SC 29210

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---|---|---|
| | (c) Amount | (d) Purpose | |
| 795 | | | 3 |

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

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

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

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

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

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

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

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

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

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

## Part II Investment and Annuity Contract Information

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

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

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

## Part III Welfare Benefit Contract Information

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

**8** Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [X] 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 | 94862 |
| **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? [X] Yes [ ] No

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

CARRIER DID NOT PROVIDE BROKER ADDRESS INFORMATION OR NAIC CODE

# 2025 Plan Information Worksheet

Status:

## Plan Sponsor Information

Plan Sponsor's Name
RESTAURANT EQUIPMENT COMPANY OF SAVANNAH

Plan Sponsor's Doing Business As Name

Plan Sponsor's Care Of Name

Plan Sponsor's EIN
58-1107870

Plan Sponsor's Phone Number
(912)236-7181

Plan Sponsor's Mailling Address
PO BOX 22354

Foreign ☐

Plan Sponsor's Mailing City, Province, State and ZIP
SAVANNAH GA 31403

Plan Sponsor's Location Address

Foreign ☐

Plan Sponsor's Location City, Province, State and ZIP

## Plan Administrator Information

☒ Same as Plan Sponsor

Plan Administrator's Name

Plan Administrator's Care Of Name

Plan Administrator's EIN

Plan Administrator's Address

Foreign ☐

Plan Administrator's City, Province, State and ZIP

Plan Administrator's Phone Number

## Plan Information

Plan Name
RESTAURANT EQUIPMENT COMPANY OF SAVANNAH EMPLOYEE BENEFIT PLAN

Business Code
[illegible]

Filing for Plan Year:
2025

DFE Plan ☐

| | MM/DD/YYYY | MM/DD/YYYY |
|---|---|---|
| Plan Year Begins | 02/01/2025 | Ends 01/31/2026 |
| Tax Year Begins | 01/01/2025 | Ends 12/31/2025 |

Three-digit Plan Number
501

Plan ID

EIN for PBGC Forms

Name Control

Effective Date of Plan
02/01/2024

## Transmitter Information

Transmitter's TIN

Transmitter Control Code (TCC)

Transmitter's Name

Company Name

Company Mailing Address

Foreign ☐

Company City, Province, State and ZIP

Contact Name

Contact Telephone Number

Contact E-Mail Address

**Do NOT File with IRS, DOL or PBGC**

## Preparer Information

Preparer's Name

Preparer's City, Province, State and ZIP

Preparer's Firm Name

Preparer's Phone Number

Preparer's Address

Foreign ☐

## Trust Information

Name of Trust

Trust EIN

Name of Trustee or Custodian

Trustee's or Custodian's Phone #

## Signers, Service Providers and Interested Individuals

☐ Notify

Contact Phone Number

Contact Name

E-Mail Address

Contact ID

☐ Notify

Contact Phone Number

Contact Name

E-Mail Address

Contact ID

☐ Notify

Contact Phone Number

Contact Name

E-Mail Address

Contact ID

☐ Notify

Contact Phone Number

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# 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

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

OMB Nos. 1210-0110
1210-0089

**2025**

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- ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
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- ☐ 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
RESTAURANT EQUIPMENT COMPANY OF SAVANNAH EMPLOYEE BENEFIT PLAN

**1b** Three-digit plan number (PN) ▶ 501

**1c** Effective date of plan 02/01/2024

**2a** Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
RESTAURANT EQUIPMENT COMPANY
OF SAVANNAH

PO BOX 22354

SAVANNAH GA 31403

**2b** Employer Identification Number (EIN) 58-1107870

**2c** Plan Sponsor's telephone number (912)236-7181

**2d** Business code (see instructions) 423400

**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** | | 3/31/26 | Jeffrey Carey |
| | **Signature of plan administrator** | Date | Enter name of individual signing as plan administrator |
| **SIGN HERE** | | 3/31/26 | Jeffrey Carey |
| | **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 ☒ 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:<br>**a** Sponsor's name<br>**c** Plan Name | **4b** EIN<br>**4d** PN | |
| **5** Total number of participants at the beginning of the plan year | **5** | 13 |
| **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**). | | |
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| **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** | 4 |
| **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)** | |
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| **h** Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested | **6h** | |
| **7** Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | **7** | |

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

**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) | | **9b** Plan benefit arrangement (check all that apply) | |
|---|---|---|---|
| (1) ☒ | Insurance | (1) ☒ | Insurance |
| (2) ☐ | Code section 412(e)(3) insurance contracts | (2) ☐ | Code section 412(e)(3) insurance contracts |
| (3) ☐ | Trust | (3) ☐ | Trust |
| (4) ☒ | General assets of the sponsor | (4) ☒ | General assets of the sponsor |

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

**a Pension Schedules**

(1) ☐ **R** (Retirement Plan Information)

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

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

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

(5) ☐ **MEP** (Multiple-Employer Retirement Plan Information)

**b General Schedules**

(1) ☐ **H** (Financial Information)

(2) ☐ **I** (Financial Information – Small Plan)

(3) ☒ **A** (Insurance Information) – Number Attached 1

(4) ☐ **C** (Service Provider Information)

(5) ☐ **D** (DFE/Participating Plan Information)

(6) ☐ **G** (Financial Transaction Schedules)

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

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

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

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

**11c** Enter the Receipt Confirmation Code for the 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 02/01/2025 and ending 01/31/2026

**A** Name of plan
RESTAURANT EQUIPMENT COMPANY OF SAVANNAH EMPLOYEE BENEFIT PLAN

**B** Three-digit plan number (PN) ▶ 501

**C** Plan sponsor's name as shown on line 2a of Form 5500
RESTAURANT EQUIPMENT COMPANY OF SAVANNAH

**D** Employer Identification Number (EIN)
58-1107870

**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

Adrem Administrators LLC

| (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 |
|---|---|---|---|---|---|
| 87-2258484 | 00000 | UT301275 | 4 | 02/01/2025 | 01/31/2026 |

**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 |
|---|---|
| 2,650 | 0 |

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

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

EbenConcepts Company
3150 North Elm
Ste 201
Greensboro NC 27408

| (b) Amount of sales and base commissions paid | Fees and other commissions paid (c) Amount | (d) Purpose | (e) Organization code |
|---|---|---|---|
| 1,855 | | | 3 |

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

Brokers Holding Group
455 St Andrew Rd
Ste E-1
Columbia SC 29210

| (b) Amount of sales and base commissions paid | Fees and other commissions paid (c) Amount | (d) Purpose | (e) Organization code |
|---|---|---|---|
| 795 | | | 3 |

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

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

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

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

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

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

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

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

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

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

**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) ☐ 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** [X] 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 | 94,862 |
| **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? [X] Yes [ ] No

**12** If the answer to line 11 is "Yes," specify the information not provided. ▶ Carrier did not provide broker address information or NAIC Code