

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 2024 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2024 or fiscal plan year beginning 11/01/2024 and ending 10/31/2025	
A	This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) ☒ a single-employer plan ☐ a DFE (specify) _____
B	This return/report is: ☐ the first return/report ☐ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C	If the plan is a collectively-bargained plan, check here. ▶ ☐
D	Check box if filing under: ☐ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶ ☐

Part II	Basic Plan Information—enter all requested information		
1a	Name of plan COMBINED WELFARE	1b	Three-digit plan number (PN) ▶ 509
		1c	Effective date of plan 11/01/2023
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) DEL NORTE CREDIT UNION ANNABEL FLORES PO BOX 1180 LOS ALAMOS, NM 87544-1180	2b	Employer Identification Number (EIN) 85-0124035
		2c	Plan Sponsor's telephone number 505-455-5415
		2d	Business code (see instructions) 522130

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.	04/23/2026	ANNABEL FLORES
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	04/23/2026	ANNABEL FLORES
	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: a Sponsor's name c Plan Name	4b EIN 4d PN
5 Total number of participants at the beginning of the plan year	5 25
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1) 25 6a(2) 205 6b 6c 6d 205 6e 6f 205 6g(1) 6g(2) 6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7

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

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

4B 4F 4H

9a Plan funding arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

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

Receipt Confirmation Code _____

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 11/01/2024 and ending 10/31/2025		
A Name of plan COMBINED WELFARE	B Three-digit plan number (PN) ▶	509
C Plan sponsor's name as shown on line 2a of Form 5500 DEL NORTE CREDIT UNION	D Employer Identification Number (EIN) 85-0124035	

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.
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1 Coverage Information:

(a) Name of insurance carrier STANDARD INSURANCE COMPANY					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0242990	69019	171761	205	11/01/2024	10/31/2025

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 10208	(b) Total amount of fees paid
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
10208			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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

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

(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** ☐ 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)	202695	
(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)	202695	
b Benefit charges (1) Claims paid	9b(1)	450859	
(2) Increase (decrease) in claim reserves	9b(2)	-89570	
(3) Incurred claims (add (1) and (2))	9b(3)	361289	
(4) Claims charged	9b(4)		
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)	10208	
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)	38325	
(E) Taxes	9c(1)(E)	5607	
(F) Charges for risks or other contingencies	9c(1)(F)	15402	
(G) Other retention charges	9c(1)(G)	102566	
(H) Total retention	9c(1)(H)	172108	
(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)	30461	
(3) Other reserves	9d(3)		
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	9e		

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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



LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION
IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500
IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: DEL NORTE CREDIT UNION

PART I

1) COVERAGE - LIFE INSURANCE

a) CARRIER: Standard Insurance Company
b) EIN: 93-0242990
c) NAIC CODE: 000-69019
d) CONTRACT NUMBER: 171761
e) NUMBER OF PERSONS COVERED: 205
f) FROM: 11/1/2024
g) TO: 10/31/2025

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID: \$4,333.98
FEES PAID / AMOUNT: \$0.00

A) NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID	B) AMOUNT OF COMMISSION PAID			FEES PAID		E) ORG. CODE
	COMM.	CONT. COMP*	GA OVR.	C) AMOUNT	D) PURPOSE	
ALBERT RHODES 10115 CALLE PLACIDO NW ALBUQUERQUE, NM 87114	\$4,333.98	\$0.00	\$0.00	\$0.00		3
TOTAL COMMISSIONS PAID				\$4,333.98		
TOTAL CONTINGENT COMP PAID				\$0.00		
TOTAL GA OVERRIDES PAID				\$0.00		

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

LONG FORM INFORMATION

PART III - 171761
 7) BENEFIT TYPE: LIFE INSURANCE

EXPERIENCE RATED CONTRACTS

a) PREMIUMS: (1) AMOUNT RECEIVED:	\$111,331.97	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID:	\$0.00	
(3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE:	\$0.00	\$111,331.97
(4) EARNED PREMIUM ((1)+(2) - (3)):		
b) BENEFIT CHARGES: (1) CLAIMS PAID:	\$400,000.00	
(2) INCREASE (DECREASE) CLAIM RESERVES:	\$47.00	
(3) INCURRED CLAIMS ((1)+(2)):		\$400,047.00
(4) CLAIMS CHARGED:		\$400,047.00
c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:		
(A) COMMISSIONS:	\$4,333.98	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES:	\$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS:	\$0.00	
(D) OTHER EXPENSES:	\$17,194.41	
(E) TAXES:	\$3,090.78	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES:	\$8,234.00	
(G) OTHER RETENTION CHARGES:	\$0.00	
(H) TOTAL RETENTION:		\$32,853.17
ci) DIVIDEND OR RETROACTIVE RATE REFUND:		
d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR		
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT		\$ 0.00
(2) CLAIM RESERVES:		\$16,918.00
(3) OTHER RESERVES:		\$0.00
di) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE:		\$0.00



LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION
IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500
IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: DEL NORTE CREDIT UNION

PART I

1) COVERAGE - LONG TERM DISABILITY

a) CARRIER: Standard Insurance Company
b) EIN: 93-0242990
c) NAIC CODE: 000-69019
d) CONTRACT NUMBER: 171761
e) NUMBER OF PERSONS COVERED: 205
f) FROM: 11/1/2024
g) TO: 10/31/2025

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID:		\$2,943.74			
FEES PAID / AMOUNT:		\$0.00			
A) NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID	B) AMOUNT OF COMMISSION PAID			FEES PAID	E) ORG.
	COMM.	CONT. COMP*	GA OVR.	C) AMOUNT	D) PURPOSE
ALBERT RHODES	\$2,943.74	\$0.00	\$0.00	\$0.00	3
10115 CALLE PLACIDO NW					
ALBUQUERQUE, NM 87114					
TOTAL COMMISSIONS PAID				\$2,943.74	
TOTAL CONTINGENT COMP PAID				\$0.00	
TOTAL GA OVERRIDES PAID				\$0.00	

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

LONG FORM INFORMATION

PART III - 171761
 7) BENEFIT TYPE: LONG TERM DISABILITY

EXPERIENCE RATED CONTRACTS

a) PREMIUMS: (1) AMOUNT RECEIVED:	\$29,011.85	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID:	\$0.00	
(3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE:	\$0.00	\$29,011.85
(4) EARNED PREMIUM ((1)+(2) - (3)):		
b) BENEFIT CHARGES: (1) CLAIMS PAID:	\$4,649.68	
(2) INCREASE (DECREASE) CLAIM RESERVES:	(\$89,838.06)	
(3) INCURRED CLAIMS ((1)+(2)):		(\$85,188.38)
(4) CLAIMS CHARGED:		(\$85,188.38)
c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:		
(A) COMMISSIONS:	\$2,943.74	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES:	\$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS:	\$0.00	
(D) OTHER EXPENSES:	\$4,779.55	
(E) TAXES:	\$782.76	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES:	\$3,127.00	
(G) OTHER RETENTION CHARGES:	\$102,566.33	
(H) TOTAL RETENTION:		\$114,199.38
ci) DIVIDEND OR RETROACTIVE RATE REFUND:		
d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR		
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT		\$ 0.00
(2) CLAIM RESERVES:		\$7,495.00
(3) OTHER RESERVES:		\$0.00
di) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE:		\$0.00



LONG FORM INFORMATION

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IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500
IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: DEL NORTE CREDIT UNION

PART I

1) COVERAGE - TEMPORARY DISABILITY

a) CARRIER: Standard Insurance Company
b) EIN: 93-0242990
c) NAIC CODE: 000-69019
d) CONTRACT NUMBER: 171761
e) NUMBER OF PERSONS COVERED: 205
f) FROM: 11/1/2024
g) TO: 10/31/2025

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID: \$2,930.47
FEES PAID / AMOUNT: \$0.00

A) NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID	B) AMOUNT OF COMMISSION PAID			FEES PAID		E) ORG. CODE
	COMM.	CONT. COMP*	GA OVR.	C) AMOUNT	D) PURPOSE	
ALBERT RHODES 10115 CALLE PLACIDO NW ALBUQUERQUE, NM 87114	\$2,930.47	\$0.00	\$0.00	\$0.00		3
TOTAL COMMISSIONS PAID				\$2,930.47		
TOTAL CONTINGENT COMP PAID				\$0.00		
TOTAL GA OVERRIDES PAID				\$0.00		

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

LONG FORM INFORMATION

PART III - 171761
 7) BENEFIT TYPE: TEMPORARY DISABILITY

EXPERIENCE RATED CONTRACTS

a) PREMIUMS: (1) AMOUNT RECEIVED:	\$62,350.74	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID:	\$0.00	
(3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE:	\$0.00	
(4) EARNED PREMIUM ((1)+(2) - (3)):		\$62,350.74
b) BENEFIT CHARGES: (1) CLAIMS PAID:	\$46,209.76	
(2) INCREASE (DECREASE) CLAIM RESERVES:	\$221.00	
(3) INCURRED CLAIMS ((1)+(2)):		\$46,430.76
(4) CLAIMS CHARGED:		\$46,430.76

c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:

(A) COMMISSIONS:	\$2,930.47	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES:	\$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS:	\$0.00	
(D) OTHER EXPENSES:	\$16,350.96	
(E) TAXES:	\$1,733.54	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES:	\$4,041.00	
(G) OTHER RETENTION CHARGES:	\$0.00	
(H) TOTAL RETENTION:		\$25,055.97

ci) DIVIDEND OR RETROACTIVE RATE REFUND:

d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR

(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT	\$ 0.00
(2) CLAIM RESERVES:	\$6,048.00
(3) OTHER RESERVES:	\$0.00

di) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE:	\$0.00
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