

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 JUSTWORKS GROUP HEALTH & WELFARE PLAN
1b	Three-digit plan number (PN) ▶ 501
1c	Effective date of plan 09/01/2004
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) JUSTWORKS EMPLOYMENT GROUP LLC CHURCH STREET STATION PO BOX 7119 NEW YORK, NY 10008-7119
2b	Employer Identification Number (EIN) 46-2283648
2c	Plan Sponsor's telephone number 888-534-1711
2d	Business code (see instructions) 561300

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.	04/24/2026	DAVID FEINBERG
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	04/24/2026	DAVID FEINBERG
	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	131268
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)	131268
	6a(2)	153848
	6b	
	6c	
	6d	153848
	6e	
	6f	153848
	6g(1)	
	6g(2)	
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

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

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

4A 4B 4D 4E 4F 4H 4L

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 13
- (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 JUSTWORKS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC	D Employer Identification Number (EIN) 46-2283648	

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 AETNA LIFE INSURANCE CO.

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-6033492		0868062	179301	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.
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(a) Total amount of commissions paid 2271280	(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	

(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) ☐ 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)	70979312	
(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)		70979312
b Benefit charges (1) Claims paid	9b(1)	54098405	
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))	9b(3)		54098405
(4) Claims charged	9b(4)		
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)	170801	
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)	11193322	
(E) Taxes	9c(1)(E)	144303	
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention	9c(1)(H)		11508426
(2) Dividends or retroactive rate refunds. (These amounts were ☒ paid in cash, or ☐ credited.)	9c(2)		5372481
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		5372481

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	1426758490
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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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 JUSTWORKS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC	D Employer Identification Number (EIN) 46-2283648	

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
AETNA HEALTH, INC.

(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
		0868062HNO	964	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	(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		(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	

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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

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	(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)		
(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)	0
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	6044330
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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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 JUSTWORKS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC	D Employer Identification Number (EIN) 46-2283648	

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
UNITEDHEALTHCARE 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
36-2739571	79413	1662634	15505	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	(b) Total amount of fees paid
0	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

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

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	(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)		
(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	63445559
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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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 JUSTWORKS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC	D Employer Identification Number (EIN) 46-2283648	

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 METROPOLITAN LIFE INSURANCE COMPANY					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0215166	162220	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 814616	(b) Total amount of fees paid 248909
--	---

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 JUSTWORKS INSURANCE SERVICES 55 WATER ST FL 29 NEW YORK, NY 10041-0007
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
814616	248909	SUPPLEMENTAL COMPENSATION	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	

(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)		
(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	16150925
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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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 JUSTWORKS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC	D Employer Identification Number (EIN) 46-2283648	

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
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0214990	235584	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 1333171	(b) Total amount of fees paid 106868
---	---

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
JUSTWORKS INSURANCE SERVICES
55 WATER ST FL 29
NEW YORK, NY 10041-0007

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1333171	106868		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	

(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) ▶ **ADD**

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	27615892
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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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 JUSTWORKS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC	D Employer Identification Number (EIN) 46-2283648	

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
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0235676	60888	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 1063272	(b) Total amount of fees paid 114311
---	---

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
JUSTWORKS INSURANCE SERVICES
55 WATER ST FL 29
NEW YORK, NY 10041-0007

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1063272	114311		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	

(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)	35628215	
(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)	35628215	
b Benefit charges (1) Claims paid	9b(1)	28658827	
(2) Increase (decrease) in claim reserves	9b(2)	1535	
(3) Incurred claims (add (1) and (2))	9b(3)	28660362	
(4) Claims charged	9b(4)		
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)	1063272	
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)	1805738	
(E) Taxes	9c(1)(E)	664485	
(F) Charges for risks or other contingencies	9c(1)(F)	712564	
(G) Other retention charges	9c(1)(G)	-9996	
(H) Total retention	9c(1)(H)	4236063	
(2) Dividends or retroactive rate refunds. (These amounts were ☒ paid in cash, or ☐ credited.)	9c(2)	2731790	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9d(1)		
(2) Claim reserves	9d(2)	2092094	
(3) Other reserves	9d(3)	1781411	
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. ▶

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 JUSTWORKS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC	D Employer Identification Number (EIN) 46-2283648	

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 KAISER FOUNDATION HEALTH PLAN OF COLORADO
--

(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
84-0591617	95669	47334	92	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	(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		(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) ☐ 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	439908
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500. ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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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 JUSTWORKS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ►	501
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC	D Employer Identification Number (EIN) 46-2283648	

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 KAISER FOUNDATION HEALTH PLAN OF GEORGIA, INC.

(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
58-1592076	96237	10443	129	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	(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		(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) ☐ 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	811549
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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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 JUSTWORKS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC	D Employer Identification Number (EIN) 46-2283648	

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 KAISER FOUNDATION HEALTH PLAN, INC.
--

(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
94-1340523	60053	11209	182	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	(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		(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) ☐ 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	980749
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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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 JUSTWORKS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC	D Employer Identification Number (EIN) 46-2283648	

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
KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

(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
52-0954463	95639	27740	117	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	(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		(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) ☐ 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	647834
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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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 JUSTWORKS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC	D Employer Identification Number (EIN) 46-2283648	

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
KAISER FOUNDATION HEALTH PLAN, INC.

(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
94-1340523	00000	606292	2614	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	(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		(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) ☐ 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	16238393
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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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 JUSTWORKS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC	D Employer Identification Number (EIN) 46-2283648	

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
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

(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
93-0798039	95540	22499	80	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	(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		(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) ☐ 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	461615
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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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 JUSTWORKS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC	D Employer Identification Number (EIN) 46-2283648	

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
KAISER FOUNDATION HEALTH PLAN, INC

(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
94-1340523	00000	234402	1532	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	(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		(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) ☐ 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	7905920
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. ▶



Attention: 5500 Central Team
3840 Murphy Canyon Road
San Diego, CA 92123

JUSTWORKS EMPLOYMENT GROUP LLC
2100 THORNTON AVE 3RD FLOOR
BURBANK, CA 91504

Reporting Period: 11/2024 - 10/2025

January 30, 2026

Dear JUSTWORKS EMPLOYMENT GROUP LLC:

Enclosed is your information from Kaiser Foundation Health Plan of Colorado that may assist you in completing the Schedule A to the Form 5500. The enclosed report provides you with the following information:

- Kaiser Foundation Health Plan of Colorado Employer Identification Number (EIN) and National Association of Insurance Commissioners (NAIC) code.
- The name and address of your broker, or other agent working on your behalf, who received compensation from Kaiser Foundation Health Plan of Colorado during your plan's contract year.
- The amount of sales and base commissions paid to your broker, or other agent working on your behalf, during your plan's contract year.
- The amount of any fees paid to your broker, or other agent working on your behalf during your plan's contract year. (Please note that bonus payments and non-monetary compensation are defined as fees on the actual Schedule A to the Form 5500.)
- The approximate number of covered persons as of the last day of your plan's contract year. (The approximate number of covered persons includes the number of health plan subscribers in addition to their spouses and dependents, if any.)
- The total amount of premiums applied by Kaiser Foundation Health Plan of Colorado during your plan's contract year.

Please be aware that the amount of premium dollars provided on the enclosed report is based on the date Kaiser Foundation Health Plan of Colorado posted the premium payment to your account. The enclosed premium information is not based on coverage or billing periods.

Kaiser Foundation Health Plan of Colorado is providing the enclosed information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completion of Schedule A to the Form 5500. If you feel you have received this information in error and do not file the Form 5500, please contact your Kaiser Permanente representative to request to have this report discontinued in future years. If you are unsure about your requirement to file the Form 5500 you should contact your broker, tax advisor, legal counsel or other qualified advisor for guidance. Kaiser Permanente is unable to help determine if you are required to file the Form 5500.

We at Kaiser Foundation Health Plan of Colorado value our business relationship with you and trust that you share our philosophy of maintaining the highest ethical standards of business practices. Our practices for broker compensation disclosure reporting reflect our shared commitment to full compliance with the law. Thank you for your continued support.

Sincerely,
Kaiser Foundation Health Plan of Colorado
5500-Central-Team@kp.org

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INSURANCE INFORMATION

Insurance companies are required to provide the following information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completing the Schedule A of your Form 5500.

Part I: Information Concerning Insurance Coverage, Fees, and Commissions

Name of Insurance Carrier: Kaiser Foundation Health Plan of Colorado
Plan Sponsor's Name: JUSTWORKS EMPLOYMENT GROUP LLC

Information Concerning Insurance Contract Coverage

Kaiser Foundation Health Plan Region: CO
Insurance Carrier: Kaiser Foundation Health Plan of Colorado
Insurance Carrier Employer Identification Number: 84-0591617
Insurance Carrier NAIC Code: 95669
Plan Sponsor Contract or Identification Number: 47334
Approximate number of persons covered at end of policy contract year: 92
Contract Year from 11/2024 - 10/2025

Information Concerning Insurance Contract Fees and Commissions

Total Amount of Commissions Paid: \$0.00
Total Amount of Fees Paid: \$0.00

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

Part II: Investment and Annuity Contract Information

Kaiser Foundation Health Plan of Colorado is not offering you an investment or annuity contract.

Part III: Welfare Benefit Contract Information

Premium applied by Kaiser Foundation Health Plan of Colorado during your plan's contract year:
\$439,908.36

Part IV: Provision of Information

Kaiser Foundation Health Plan, Inc. hereby certifies that the foregoing statement furnished pursuant to 29 US Code of Federal Regulations 2520.103(c) is complete and accurate.



Laura Sokolowski
Vice President, Commercial Membership Administration
Kaiser Foundation Health Plan, Inc
January 30, 2026

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Attention: 5500 Central Team
3840 Murphy Canyon Road
San Diego, CA 92123

JUSTWORKS EMPLOYMENT GROUP LLC
1800 HARRISON ST.
9TH FLOOR
OAKLAND, CA 94612

Reporting Period: 11/2024 - 10/2025

January 30, 2026

Dear JUSTWORKS EMPLOYMENT GROUP LLC:

Enclosed is your information from Kaiser Foundation Health Plan of Georgia, Inc. that may assist you in completing the Schedule A to the Form 5500. The enclosed report provides you with the following information:

- Kaiser Foundation Health Plan of Georgia, Inc. Employer Identification Number (EIN) and National Association of Insurance Commissioners (NAIC) code.
- The name and address of your broker, or other agent working on your behalf, who received compensation from Kaiser Foundation Health Plan of Georgia, Inc. during your plan's contract year.
- The amount of sales and base commissions paid to your broker, or other agent working on your behalf, during your plan's contract year.
- The amount of any fees paid to your broker, or other agent working on your behalf during your plan's contract year. (Please note that bonus payments and non-monetary compensation are defined as fees on the actual Schedule A to the Form 5500.)
- The approximate number of covered persons as of the last day of your plan's contract year. (The approximate number of covered persons includes the number of health plan subscribers in addition to their spouses and dependents, if any.)
- The total amount of premiums applied by Kaiser Foundation Health Plan of Georgia, Inc. during your plan's contract year.

Please be aware that the amount of premium dollars provided on the enclosed report is based on the date Kaiser Foundation Health Plan of Georgia, Inc. posted the premium payment to your account. The enclosed premium information is not based on coverage or billing periods.

Kaiser Foundation Health Plan of Georgia, Inc. is providing the enclosed information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completion of Schedule A to the Form 5500. If you feel you have received this information in error and do not file the Form 5500, please contact your Kaiser Permanente representative to request to have this report discontinued in future years. If you are unsure about your requirement to file the Form 5500 you should contact your broker, tax advisor, legal counsel or other qualified advisor for guidance. Kaiser Permanente is unable to help determine if you are required to file the Form 5500.

We at Kaiser Foundation Health Plan of Georgia, Inc. value our business relationship with you and trust that you share our philosophy of maintaining the highest ethical standards of business practices. Our practices for broker compensation disclosure reporting reflect our shared commitment to full compliance with the law. Thank you for your continued support.

Sincerely,
Kaiser Foundation Health Plan of Georgia, Inc.
5500-Central-Team@kp.org

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INSURANCE INFORMATION

Insurance companies are required to provide the following information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completing the Schedule A of your Form 5500.

Part I: Information Concerning Insurance Coverage, Fees, and Commissions

Name of Insurance Carrier: Kaiser Foundation Health Plan of Georgia, Inc.
Plan Sponsor's Name: JUSTWORKS EMPLOYMENT GROUP LLC

Information Concerning Insurance Contract Coverage

Kaiser Foundation Health Plan Region: GA
Insurance Carrier: Kaiser Foundation Health Plan of Georgia, Inc.
Insurance Carrier Employer Identification Number: 58-1592076
Insurance Carrier NAIC Code: 96237
Plan Sponsor Contract or Identification Number: 10443
Approximate number of persons covered at end of policy contract year: 129
Contract Year from 11/2024 - 10/2025

Information Concerning Insurance Contract Fees and Commissions

Total Amount of Commissions Paid: \$0.00
Total Amount of Fees Paid: \$0.00

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

Part II: Investment and Annuity Contract Information

Kaiser Foundation Health Plan of Georgia, Inc. is not offering you an investment or annuity contract.

Part III: Welfare Benefit Contract Information

Premium applied by Kaiser Foundation Health Plan of Georgia, Inc. during your plan's contract year:
\$811,549.40

Part IV: Provision of Information

Kaiser Foundation Health Plan, Inc. hereby certifies that the foregoing statement furnished pursuant to 29 US Code of Federal Regulations 2520.103(c) is complete and accurate.



Laura Sokolowski
Vice President, Commercial Membership Administration
Kaiser Foundation Health Plan, Inc
January 30, 2026

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Attention: 5500 Central Team
3840 Murphy Canyon Road
San Diego, CA 92123

JUSTWORKS EMPLOYMENT GROUP LLC
PO BOX 7119
CHURCH STREET STATION
NEW YORK, NY 10008

Reporting Period: 11/2024 - 10/2025

January 30, 2026

Dear JUSTWORKS EMPLOYMENT GROUP LLC:

Enclosed is your information from Kaiser Foundation Health Plan, Inc. that may assist you in completing the Schedule A to the Form 5500. The enclosed report provides you with the following information:

- Kaiser Foundation Health Plan, Inc. Employer Identification Number (EIN) and National Association of Insurance Commissioners (NAIC) code.
- The name and address of your broker, or other agent working on your behalf, who received compensation from Kaiser Foundation Health Plan, Inc. during your plan's contract year.
- The amount of sales and base commissions paid to your broker, or other agent working on your behalf, during your plan's contract year.
- The amount of any fees paid to your broker, or other agent working on your behalf during your plan's contract year. (Please note that bonus payments and non-monetary compensation are defined as fees on the actual Schedule A to the Form 5500.)
- The approximate number of covered persons as of the last day of your plan's contract year. (The approximate number of covered persons includes the number of health plan subscribers in addition to their spouses and dependents, if any.)
- The total amount of premiums applied by Kaiser Foundation Health Plan, Inc. during your plan's contract year.

Please be aware that the amount of premium dollars provided on the enclosed report is based on the date Kaiser Foundation Health Plan, Inc. posted the premium payment to your account. The enclosed premium information is not based on coverage or billing periods.

Kaiser Foundation Health Plan, Inc. is providing the enclosed information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completion of Schedule A to the Form 5500. If you feel you have received this information in error and do not file the Form 5500, please contact your Kaiser Permanente representative to request to have this report discontinued in future years. If you are unsure about your requirement to file the Form 5500 you should contact your broker, tax advisor, legal counsel or other qualified advisor for guidance. Kaiser Permanente is unable to help determine if you are required to file the Form 5500.

We at Kaiser Foundation Health Plan, Inc. value our business relationship with you and trust that you share our philosophy of maintaining the highest ethical standards of business practices. Our practices for broker compensation disclosure reporting reflect our shared commitment to full compliance with the law. Thank you for your continued support.

Sincerely,
Kaiser Foundation Health Plan, Inc.
5500-Central-Team@kp.org

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INSURANCE INFORMATION

Insurance companies are required to provide the following information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completing the Schedule A of your Form 5500.

Part I: Information Concerning Insurance Coverage, Fees, and Commissions

Name of Insurance Carrier: Kaiser Foundation Health Plan, Inc.
Plan Sponsor's Name: JUSTWORKS EMPLOYMENT GROUP LLC

Information Concerning Insurance Contract Coverage

Kaiser Foundation Health Plan Region: HI
Insurance Carrier: Kaiser Foundation Health Plan, Inc.
Insurance Carrier Employer Identification Number: 94-1340523
Insurance Carrier NAIC Code: 60053
Plan Sponsor Contract or Identification Number: 11209
Approximate number of persons covered at end of policy contract year: 182
Contract Year from 11/2024 - 10/2025

Information Concerning Insurance Contract Fees and Commissions

Total Amount of Commissions Paid: \$0.00
Total Amount of Fees Paid: \$0.00

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

None

Amount of sales and base commissions paid to None \$0.00
Fees and other compensation paid to None: \$0.00
Bonus Amount: \$0.00
Bonus Purpose: None
Value of Non-Monetary Compensation: \$0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00
Fees and other compensation paid to None: \$0.00
Bonus Amount: \$0.00
Bonus Purpose: None
Value of Non-Monetary Compensation: \$0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

Part II: Investment and Annuity Contract Information

Kaiser Foundation Health Plan, Inc. is not offering you an investment or annuity contract.

Part III: Welfare Benefit Contract Information

Premium applied by Kaiser Foundation Health Plan, Inc. during your plan's contract year: \$980,749.07

Part IV: Provision of Information

Kaiser Foundation Health Plan, Inc. hereby certifies that the foregoing statement furnished pursuant to 29 US Code of Federal Regulations 2520.103(c) is complete and accurate.



Laura Sokolowski
Vice President, Commercial Membership Administration
Kaiser Foundation Health Plan, Inc
January 30, 2026

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Attention: 5500 Central Team
3840 Murphy Canyon Road
San Diego, CA 92123

JUSTWORKS DHMO500_0.94
55 WATER ST FL 29
NEW YORK, NY 10041

Reporting Period: 11/2024 - 10/2025

January 27, 2026

Dear JUSTWORKS DHMO500_0.94:

Enclosed is your information from Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. that may assist you in completing the Schedule A to the Form 5500. The enclosed report provides you with the following information:

- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Employer Identification Number (EIN) and National Association of Insurance Commissioners (NAIC) code.
- The name and address of your broker, or other agent working on your behalf, who received compensation from Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. during your plan's contract year.
- The amount of sales and base commissions paid to your broker, or other agent working on your behalf, during your plan's contract year.
- The amount of any fees paid to your broker, or other agent working on your behalf during your plan's contract year. (Please note that bonus payments and non-monetary compensation are defined as fees on the actual Schedule A to the Form 5500.)
- The approximate number of covered persons as of the last day of your plan's contract year. (The approximate number of covered persons includes the number of health plan subscribers in addition to their spouses and dependents, if any.)
- The total amount of premiums applied by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. during your plan's contract year.

Please be aware that the amount of premium dollars provided on the enclosed report is based on the date Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. posted the premium payment to your account. The enclosed premium information is not based on coverage or billing periods.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. is providing the enclosed information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completion of Schedule A to the Form 5500. If you feel you have received this information in error and do not file the Form 5500, please contact your Kaiser Permanente representative to request to have this report discontinued in future years. If you are unsure about your requirement to file the Form 5500 you should contact your broker, tax advisor, legal counsel or other qualified advisor for guidance. Kaiser Permanente is unable to help determine if you are required to file the Form 5500.

We at Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. value our business relationship with you and trust that you share our philosophy of maintaining the highest ethical standards of business practices. Our practices for broker compensation disclosure reporting reflect our shared commitment to full compliance with the law. Thank you for your continued support.

Sincerely,
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
5500-Central-Team@kp.org

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INSURANCE INFORMATION

Insurance companies are required to provide the following information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completing the Schedule A of your Form 5500.

Part I: Information Concerning Insurance Coverage, Fees, and Commissions

Name of Insurance Carrier: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Plan Sponsor's Name: JUSTWORKS DHMO500_0.94

Information Concerning Insurance Contract Coverage

Kaiser Foundation Health Plan Region: MA
Insurance Carrier: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Insurance Carrier Employer Identification Number: 52-0954463
Insurance Carrier NAIC Code: 95639
Plan Sponsor Contract or Identification Number: 27740
Approximate number of persons covered at end of policy contract year: 117
Contract Year from 11/2024 - 10/2025

Information Concerning Insurance Contract Fees and Commissions

Total Amount of Commissions Paid: \$0.00
Total Amount of Fees Paid: \$0.00

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

Part II: Investment and Annuity Contract Information

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. is not offering you an investment or annuity contract.

Part III: Welfare Benefit Contract Information

Premium applied by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. during your plan's contract year: \$647,834.49

Part IV: Provision of Information

Kaiser Foundation Health Plan, Inc. hereby certifies that the foregoing statement furnished pursuant to 29 US Code of Federal Regulations 2520.103(c) is complete and accurate.



Laura Sokolowski
Vice President, Commercial Membership Administration
Kaiser Foundation Health Plan, Inc
January 27, 2026

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Attention: 5500 Central Team
3840 Murphy Canyon Road
San Diego, CA 92123

JUSTWORKS EMPLOYMENT GROUP LLC
55 WATER ST, 29TH FL
4TH FLOOR
NEW YORK, NY 10041

Reporting Period: 11/2024 - 10/2025

January 30, 2026

Dear JUSTWORKS EMPLOYMENT GROUP LLC:

Enclosed is your information from Kaiser Foundation Health Plan of the Northwest that may assist you in completing the Schedule A to the Form 5500. The enclosed report provides you with the following information:

- Kaiser Foundation Health Plan of the Northwest Employer Identification Number (EIN) and National Association of Insurance Commissioners (NAIC) code.
- The name and address of your broker, or other agent working on your behalf, who received compensation from Kaiser Foundation Health Plan of the Northwest during your plan's contract year.
- The amount of sales and base commissions paid to your broker, or other agent working on your behalf, during your plan's contract year.
- The amount of any fees paid to your broker, or other agent working on your behalf during your plan's contract year. (Please note that bonus payments and non-monetary compensation are defined as fees on the actual Schedule A to the Form 5500.)
- The approximate number of covered persons as of the last day of your plan's contract year. (The approximate number of covered persons includes the number of health plan subscribers in addition to their spouses and dependents, if any.)
- The total amount of premiums applied by Kaiser Foundation Health Plan of the Northwest during your plan's contract year.

Please be aware that the amount of premium dollars provided on the enclosed report is based on the date Kaiser Foundation Health Plan of the Northwest posted the premium payment to your account. The enclosed premium information is not based on coverage or billing periods.

Kaiser Foundation Health Plan of the Northwest is providing the enclosed information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completion of Schedule A to the Form 5500. If you feel you have received this information in error and do not file the Form 5500, please contact your Kaiser Permanente representative to request to have this report discontinued in future years. If you are unsure about your requirement to file the Form 5500 you should contact your broker, tax advisor, legal counsel or other qualified advisor for guidance. Kaiser Permanente is unable to help determine if you are required to file the Form 5500.

We at Kaiser Foundation Health Plan of the Northwest value our business relationship with you and trust that you share our philosophy of maintaining the highest ethical standards of business practices. Our practices for broker compensation disclosure reporting reflect our shared commitment to full compliance with the law. Thank you for your continued support.

Sincerely,
Kaiser Foundation Health Plan of the Northwest
5500-Central-Team@kp.org

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INSURANCE INFORMATION

Insurance companies are required to provide the following information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completing the Schedule A of your Form 5500.

Part I: Information Concerning Insurance Coverage, Fees, and Commissions

Name of Insurance Carrier: Kaiser Foundation Health Plan of the Northwest
Plan Sponsor's Name: JUSTWORKS EMPLOYMENT GROUP LLC

Information Concerning Insurance Contract Coverage

Kaiser Foundation Health Plan Region: NW
Insurance Carrier: Kaiser Foundation Health Plan of the Northwest
Insurance Carrier Employer Identification Number: 93-0798039
Insurance Carrier NAIC Code: 95540
Plan Sponsor Contract or Identification Number: 22499
Approximate number of persons covered at end of policy contract year: 80
Contract Year from 11/2024 - 10/2025

Information Concerning Insurance Contract Fees and Commissions

Total Amount of Commissions Paid: \$0.00
Total Amount of Fees Paid: \$0.00

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

Part II: Investment and Annuity Contract Information

Kaiser Foundation Health Plan of the Northwest is not offering you an investment or annuity contract.

Part III: Welfare Benefit Contract Information

Premium applied by Kaiser Foundation Health Plan of the Northwest during your plan's contract year:
\$461,615.98

Part IV: Provision of Information

Kaiser Foundation Health Plan, Inc. hereby certifies that the foregoing statement furnished pursuant to 29 US Code of Federal Regulations 2520.103(c) is complete and accurate.



Laura Sokolowski
Vice President, Commercial Membership Administration
Kaiser Foundation Health Plan, Inc
January 30, 2026

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Attention: 5500 Central Team
3840 Murphy Canyon Road
San Diego, CA 92123

JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIA Reporting Period: 11/2024 - 10/2025
DAVID FEINBERG
55 WATER ST FL 29
NEW YORK, NY 10041-0008

January 27, 2026

Dear JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIATES:

Enclosed is your information from Kaiser Foundation Health Plan, Inc. that may assist you in completing the Schedule A to the Form 5500. The enclosed report provides you with the following information:

- Kaiser Foundation Health Plan, Inc. Employer Identification Number (EIN) and National Association of Insurance Commissioners (NAIC) code.
- The name and address of your broker, or other agent working on your behalf, who received compensation from Kaiser Foundation Health Plan, Inc. during your plan's contract year.
- The amount of sales and base commissions paid to your broker, or other agent working on your behalf, during your plan's contract year.
- The amount of any fees paid to your broker, or other agent working on your behalf during your plan's contract year. (Please note that bonus payments and non-monetary compensation are defined as fees on the actual Schedule A to the Form 5500.)
- The approximate number of covered persons as of the last day of your plan's contract year. (The approximate number of covered persons includes the number of health plan subscribers in addition to their spouses and dependents, if any.)
- The total amount of premiums applied by Kaiser Foundation Health Plan, Inc. during your plan's contract year.

Please be aware that the amount of premium dollars provided on the enclosed report is based on the date Kaiser Foundation Health Plan, Inc. posted the premium payment to your account. The enclosed premium information is not based on coverage or billing periods.

Kaiser Foundation Health Plan, Inc. is providing the enclosed information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completion of Schedule A to the Form 5500. If you feel you have received this information in error and do not file the Form 5500, please contact your Kaiser Permanente representative to request to have this report discontinued in future years. If you are unsure about your requirement to file the Form 5500 you should contact your broker, tax advisor, legal counsel or other qualified advisor for guidance. Kaiser Permanente is unable to help determine if you are required to file the Form 5500.

We at Kaiser Foundation Health Plan, Inc. value our business relationship with you and trust that you share our philosophy of maintaining the highest ethical standards of business practices. Our practices for broker compensation disclosure reporting reflect our shared commitment to full compliance with the law. Thank you for your continued support.

Sincerely,
Kaiser Foundation Health Plan, Inc.
5500-Central-Team@kp.org

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INSURANCE INFORMATION

Insurance companies are required to provide the following information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completing the Schedule A of your Form 5500.

Part I: Information Concerning Insurance Coverage, Fees, and Commissions

Name of Insurance Carrier: Kaiser Foundation Health Plan, Inc.

Plan Sponsor's Name: JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIATES

Information Concerning Insurance Contract Coverage

Kaiser Foundation Health Plan Region: CA

Insurance Carrier: Kaiser Foundation Health Plan, Inc.

Insurance Carrier Employer Identification Number: 94-1340523

Insurance Carrier NAIC Code: 00000

Plan Sponsor Contract or Identification Number: 606292

Approximate number of persons covered at end of policy contract year: 2614

Contract Year from 11/2024 - 10/2025

Information Concerning Insurance Contract Fees and Commissions

Total Amount of Commissions Paid: \$0.00

Total Amount of Fees Paid: \$0.00

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

Part II: Investment and Annuity Contract Information

Kaiser Foundation Health Plan, Inc. is not offering you an investment or annuity contract.

Part III: Welfare Benefit Contract Information

Premium applied by Kaiser Foundation Health Plan, Inc. during your plan's contract year: \$16,238,393.37

Part IV: Provision of Information

Kaiser Foundation Health Plan, Inc. hereby certifies that the foregoing statement furnished pursuant to 29 US Code of Federal Regulations 2520.103(c) is complete and accurate.



Laura Sokolowski
Vice President, Commercial Membership Administration
Kaiser Foundation Health Plan, Inc
January 27, 2026

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Attention: 5500 Central Team
3840 Murphy Canyon Road
San Diego, CA 92123

JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIA Reporting Period: 11/2024 - 10/2025
DAVID FEINBERG
55 WATER ST FL 29
NEW YORK, NY 10041-0008

January 27, 2026

Dear JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIATES:

Enclosed is your information from Kaiser Foundation Health Plan, Inc. that may assist you in completing the Schedule A to the Form 5500. The enclosed report provides you with the following information:

- Kaiser Foundation Health Plan, Inc. Employer Identification Number (EIN) and National Association of Insurance Commissioners (NAIC) code.
- The name and address of your broker, or other agent working on your behalf, who received compensation from Kaiser Foundation Health Plan, Inc. during your plan's contract year.
- The amount of sales and base commissions paid to your broker, or other agent working on your behalf, during your plan's contract year.
- The amount of any fees paid to your broker, or other agent working on your behalf during your plan's contract year. (Please note that bonus payments and non-monetary compensation are defined as fees on the actual Schedule A to the Form 5500.)
- The approximate number of covered persons as of the last day of your plan's contract year. (The approximate number of covered persons includes the number of health plan subscribers in addition to their spouses and dependents, if any.)
- The total amount of premiums applied by Kaiser Foundation Health Plan, Inc. during your plan's contract year.

Please be aware that the amount of premium dollars provided on the enclosed report is based on the date Kaiser Foundation Health Plan, Inc. posted the premium payment to your account. The enclosed premium information is not based on coverage or billing periods.

Kaiser Foundation Health Plan, Inc. is providing the enclosed information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completion of Schedule A to the Form 5500. If you feel you have received this information in error and do not file the Form 5500, please contact your Kaiser Permanente representative to request to have this report discontinued in future years. If you are unsure about your requirement to file the Form 5500 you should contact your broker, tax advisor, legal counsel or other qualified advisor for guidance. Kaiser Permanente is unable to help determine if you are required to file the Form 5500.

We at Kaiser Foundation Health Plan, Inc. value our business relationship with you and trust that you share our philosophy of maintaining the highest ethical standards of business practices. Our practices for broker compensation disclosure reporting reflect our shared commitment to full compliance with the law. Thank you for your continued support.

Sincerely,
Kaiser Foundation Health Plan, Inc.
5500-Central-Team@kp.org

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INSURANCE INFORMATION

Insurance companies are required to provide the following information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completing the Schedule A of your Form 5500.

Part I: Information Concerning Insurance Coverage, Fees, and Commissions

Name of Insurance Carrier: Kaiser Foundation Health Plan, Inc.

Plan Sponsor's Name: JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIATES

Information Concerning Insurance Contract Coverage

Kaiser Foundation Health Plan Region: CA

Insurance Carrier: Kaiser Foundation Health Plan, Inc.

Insurance Carrier Employer Identification Number: 94-1340523

Insurance Carrier NAIC Code: 00000

Plan Sponsor Contract or Identification Number: 234402

Approximate number of persons covered at end of policy contract year: 1532

Contract Year from 11/2024 - 10/2025

Information Concerning Insurance Contract Fees and Commissions

Total Amount of Commissions Paid: \$0.00

Total Amount of Fees Paid: \$0.00

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to None \$0.00

Fees and other compensation paid to None: \$0.00

Bonus Amount: \$0.00

Bonus Purpose: None

Value of Non-Monetary Compensation: \$0.00

Type/Purpose of Non-Monetary Compensation: None

Part II: Investment and Annuity Contract Information

Kaiser Foundation Health Plan, Inc. is not offering you an investment or annuity contract.

Part III: Welfare Benefit Contract Information

Premium applied by Kaiser Foundation Health Plan, Inc. during your plan's contract year: \$7,905,920.93

Part IV: Provision of Information

Kaiser Foundation Health Plan, Inc. hereby certifies that the foregoing statement furnished pursuant to 29 US Code of Federal Regulations 2520.103(c) is complete and accurate.



Laura Sokolowski
Vice President, Commercial Membership Administration
Kaiser Foundation Health Plan, Inc
January 27, 2026

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ERISA 5500 SCHEDULE A TEAM
PO BOX 818091
CLEVELAND, OH 44181-8091

MARCH 26, 2026

JUSTWORKS EMPLOYMENT GROUP LLC
HEALTH BENEFITS OPERATIONS, BENEFIT OPERATIONS MGR
PO BOX 7119
NEW YORK, NY 10008

Re: Annual Reporting Under Employee Retirement Income Security Act of 1974 (ERISA)
For: JUSTWORKS EMPLOYMENT GROUP LLC - 0868062
Policy Period : November 01, 2024 through October 31, 2025

We have enclosed information for your policy period listed above to help you complete the Schedule A to ERISA Form 5500 Annual Report. We are providing this information in accordance with U.S. Department of Labor regulations.

Note that compliance with the ERISA requirements for completion of the Annual Report and its filing with the Internal Revenue Service is the sole responsibility of employers, plan administrators and their professional advisors. Aetna Life Insurance Co. cannot and does not assume any responsibility for such compliance, but we are pleased to provide information pertaining to your insurance program as needed to complete the Report.

Information may also be included in the enclosure(s) for your consideration in completing Schedule C of your Form 5500. This information may consist of one or more of the following: Producer Service Fees, Indirect Compensation (as it pertains to meals and entertainment) and/or Direct Billed Fees. Information pertaining to Indirect Compensation and Direct Billed Fees is provided on a calendar year basis, which may not coincide with your plan year.

If you have other benefits plans with Aetna Life Insurance Co., you may receive additional ERISA information to complete your Schedule A and Schedule C for those plans under separate cover.

If you have any additional reporting needs, please contact your Aetna Life Insurance Co. account manager, or call 1-800-818-0691 to speak with the ERISA support team.

Sincerely,

Aetna Life Insurance Co.

Enclosure(s)

868062-TR-03192026



For Fiscal Plan Year beginning 11/01/2024, and ending 10/31/2025.

C. Name of Plan Sponsor: JUSTWORKS EMPLOYMENT GROUP LLC

PART I Information Concerning Insurance Contract Coverage, Fees, and Commissions.

1. Coverage: Traditional Retrospective

(a) Name of Insurance Carrier: Aetna Life Insurance Co.	(d) Contract Number or Identification: 0868062	(e) Approximate number of persons covered at end of policy or contract year. 179,301	Policy or contract year	
(b) EIN 06-6033492			(f) From: 11/01/2024	(g) To: 10/31/2025
(c) NAIC Code: See Attached Listing				

2. Insurance fees and commissions paid to agents and brokers:

Contract or identification	(a) Name and address of the agents or brokers to whom commissions or fees were paid.	(b) Amount of commissions paid	(c) & (d) Fees Paid	
			Amount	Purpose
0868062	JUSTWORKS INSURANCE SERVICES PO BOX 7119 CHURCH ST STATION NEW YORK, NY 10008	\$2,271,280.77		
TOTAL		\$2,271,280.77		

Reported fees and commissions may be attributed to multiple Aetna companies.

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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. 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.

7 Benefit and contract type (check all applicable boxes)

☒ Health (other than dental or vision)	☒ Dental	☒ Vision	☐ Life Insurance
☐ Temporary disability (accident and sickness)	☐ Long-term disability	☐ Supplemental unemployment	☐ Prescription drug
☐ Stop loss (large deductible)	☐ HMO contract	☐ PPO contract	☐ Indemnity contract
☐ Accidental Death Dismemberment	☐ Short Term Disability		

8 Experience Rated Contracts: See Attached

9. Non experience rated contracts:

(a) Total premiums or subscription charges paid to carrier.	1,426,758,490.93
(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 2 above, report amount.	
Specify nature of costs -->	

This information was generated as of March 19, 2026.

Date **March 26, 2026 FINAL RELEASE**
Vicki Silva
Registrar

AETNA LIFE INSURANCE COMPANY AND AFFILIATES
hereby certifies that the foregoing statement is
complete and accurate

868062-TR-03192026



For Fiscal Plan Year beginning 11/01/2024, and ending 10/31/2025.
C. Name of Plan Sponsor: JUSTWORKS EMPLOYMENT GROUP LLC

8. Experience rated contracts for: 0868062		
(a) Premiums:		
(1) Amount received.	\$70,979,312.00	
(2) Increase (decrease) in amount due but unpaid.		
(3) Increase (decrease) in unearned premium reserve.		
(4) Premiums earned, (1) plus (2), minus (3).		\$70,979,312.00
(b) Benefit charges:		
(1) Claims paid.	\$54,098,405.00	
(2) Increase (decrease) in claim reserves.		
(3) Incurred claims (1) plus (2).		
(4) Claims charged.		\$54,098,405.00
(c) Remainder of premium:		
(1) Retention charges (on an accrual basis)-		
(A) Commissions.	\$170,801.00	
(B) Administrative service or other fees.		
(C) Other specific acquisition costs.		
(D) Other expenses.	\$11,193,322.00	
(E) Taxes.	\$144,303.00	
(F) Charges for risk or contingencies.		
(G) Other retention charges.		
(H) Total retention.		\$11,508,426.00
(2) Dividends or retroactive rate refunds. (Such amounts were 1) ☒ paid in cash or 2) ☐ credited)		\$5,372,481.00
(d) Status of policyholder reserves at end of year:		
(1) Amount held to provide benefits after retirement.		
(2) Claim reserves.		
(3) Other reserves.		
(e) Dividends or retroactive rate refunds due (do not include amount entered in (c) (2)).		\$5,372,481.00

868062-TR-03192026

<u>State</u>	<u>NAIC Code</u>	<u>Service Area</u>	<u>EIN</u>
	95094	Aetna Health Inc. (a Georgia Corporation)	06-6033492
	95910	Aetna Dental Inc (a Texas Corporation)	06-6033492
	60054	Aetna Life Insurance Company	06-6033492
	N/A	Aetna Dental of California Inc.	06-6033492
	11183	Aetna Dental Inc (a New Jersey Corporation)	06-6033492
	95003	Aetna Health Inc. (an Arizona Corporation)	06-6033492



ERISA 5500 SCHEDULE A TEAM
PO BOX 818091
CLEVELAND, OH 44181-8091

MARCH 26, 2026

JUSTWORKS EMPLOYMENT GROUP LLC
HEALTH BENEFITS OPERATIONS, BENEFIT OPERATIONS MGR
PO BOX 7119
NEW YORK, NY 10008

Re: Annual Reporting Under Employee Retirement Income Security Act of 1974 (ERISA)
For: JUSTWORKS EMPLOYMENT GROUP LLC - 0868062HNO
Policy Period : November 01, 2024 through October 31, 2025

We have enclosed information for your policy period listed above to help you complete the Schedule A to ERISA Form 5500 Annual Report. We are providing this information in accordance with U.S. Department of Labor regulations.

Note that compliance with the ERISA requirements for completion of the Annual Report and its filing with the Internal Revenue Service is the sole responsibility of employers, plan administrators and their professional advisors. Aetna Health, Inc. cannot and does not assume any responsibility for such compliance, but we are pleased to provide information pertaining to your insurance program as needed to complete the Report.

Information may also be included in the enclosure(s) for your consideration in completing Schedule C of your Form 5500. This information may consist of one or more of the following: Producer Service Fees, Indirect Compensation (as it pertains to meals and entertainment) and/or Direct Billed Fees. Information pertaining to Indirect Compensation and Direct Billed Fees is provided on a calendar year basis, which may not coincide with your plan year.

If you have other benefits plans with Aetna Health, Inc., you may receive additional ERISA information to complete your Schedule A and Schedule C for those plans under separate cover.

If you have any additional reporting needs, please contact your Aetna Health, Inc. account manager, or call 1-800-818-0691 to speak with the ERISA support team.

Sincerely,

Aetna Health, Inc.

Enclosure(s)

868062HNO-HN-03192026



For Fiscal Plan Year beginning 11/01/2024, and ending 10/31/2025.

C. Name of Plan Sponsor: JUSTWORKS EMPLOYMENT GROUP LLC

PART I Information Concerning Insurance Contract Coverage, Fees, and Commissions.

1. Coverage: HNO Prospective

(a) Name of Insurance Carrier: Aetna Health, Inc.	(d) Contract Number or Identification: 0868062HNO	(e) Approximate number of persons covered at end of policy or contract year. 964	Policy or contract year	
(b) EIN See Attached			(f) From: 11/01/2024	(g) To: 10/31/2025
(c) NAIC Code: See Attached Listing				

2. Insurance fees and commissions paid to agents and brokers:

Contract or identification	(a) Name and address of the agents or brokers to whom commissions or fees were paid.	(b) Amount of commissions paid	(c) & (d) Fees Paid	
			Amount	Purpose
TOTAL				

Reported fees and commissions may be attributed to multiple Aetna companies.

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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. 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.

7 Benefit and contract type (check all applicable boxes)

☐ Health (other than dental or vision)	☐ Dental	☐ Vision	☐ Life Insurance
☐ Temporary disability (accident and sickness)	☐ Long-term disability	☐ Supplemental unemployment	☐ Prescription drug
☐ Stop loss (large deductible)	☒ HMO contract	☐ PPO contract	☐ Indemnity contract
☐ Accidental Death Dismemberment	☐ Short Term Disability		

8 Experience Rated Contracts: N/A

9. Non experience rated contracts:

(a) Total premiums or subscription charges paid to carrier.	\$6,044,330.11
(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 2 above, report amount.	
Specify nature of costs -->	

This information was generated as of March 19, 2026.

Date **March 23, 2026 FINAL RELEASE**
Vicki Silva
Registrar

AETNA LIFE INSURANCE COMPANY AND AFFILIATES
hereby certifies that the foregoing statement is
complete and accurate

868062HNO-HN-03192026

<u>State</u>	<u>NAIC Code</u>	<u>Service Area</u>	<u>EIN</u>
WA	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
CT	95935	Aetna Heath Inc. (a Connecticut Corporation)	23-2442048
CO	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
TX	95490	Aetna Health Inc. (a Texas Corporation)	76-0189680
VA	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
TN	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
PA	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
OK	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
OH	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
NY	95234	Aetna Health Inc. (a New York Corporation)	22-2663623
NV	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
VA	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
MO	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
CA	0	Aetna Health of California Inc. (a California Corporation)	95-3402799
IL	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
DE	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
FL	95088	Aetna Health Inc. (a Florida Corporation)	59-2411584
GA	95094	Aetna Health Inc. (a Georgia Corporation)	58-1649568
NJ	95287	Aetna Health Inc. (a New Jersey Corporation)	52-1270921
KS	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
MI	95756	Aetna Health Inc. (a Michigan Corporation)	23-2861565
KY	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
AZ	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
LA	95173	Aetna Health Inc. (a Louisiana Corporation)	74-2381406
MA	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
MD	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745
ME	95517	Aetna Health Inc. (a Maine Corporation)	01-0504252
NC	95109	Aetna Health Inc. (a Pennsylvania Corporation)	23-2169745



February 6, 2026

ATTENTION: DAVID FEINBERG
JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIA
CHURCH STREET STATION, P.O. BOX 7119
NEW YORK, NY 10008

The Employee Retirement Income Security Act of 1974 ("ERISA") requires an annual financial report on employee welfare benefit plans and pension benefit plans which cover 100 or more participants at the beginning of the plan year and are subject to ERISA. The administrator of such a plan is required to file an annual report on I.R.S./DOL Form 5500, including the accompanying Schedule A, with the Employee Benefits Security Administration.

Your Metropolitan Life Insurance Company ("MetLife") employee welfare benefit plan may be subject to ERISA's annual reporting requirements and MetLife is therefore providing you with the information needed to complete Schedule A of Form 5500. The attached report is not an actual Schedule A form and should not be attached to the Form 5500 for regulatory filing. The information should be forwarded to the person who will be completing your annual filing. The information is taken from the data MetLife maintains within its normal business records and is, to the best of MetLife's knowledge and belief, complete and accurate.

Part I, Section 2 of this report lists the compensation paid to intermediaries related to your plan. Intermediaries may include brokers, consultants, agents and third-party administrators. There are several categories of compensation that may be paid to an intermediary. For your reference, the categories of compensation are listed below.

- Base Commissions - Base commissions are generally paid to an intermediary on a monthly basis and are usually calculated as a percentage of premium. Base commissions are typically factored into the cost of the customer's plan.
- Supplemental Compensation - Supplemental compensation may be paid to qualifying intermediaries based on an intermediary's new business or total inforce premium for a specified year. It is not MetLife's practice to specifically factor supplemental compensation into the cost of customer's plan. Supplemental compensation is factored into the price structure of MetLife's institutional business products.
- Fees - Fees may include payments made to intermediaries for services such as administration, communication, enrollment, billing, eligibility, recordkeeping, printing and mailing. Fees may be directly charged to the customer's plan.
- Award - If your intermediary received an award (such as travel or a gift) from MetLife, MetLife allocated the value of the award to all plans that were considered in the qualification criteria proportionately.

Note, the non-monetary compensation amount included in the Schedule A, Fees Paid section of the enclosed report is based on the calendar year tracking of all individual gifts or items of non-monetary compensation such as dinners, tickets for shows or other entertainment events, membership dues, hotels, equal to or greater than \$10, that are given to or provided directly or indirectly to brokers, producers, and other insurance intermediaries and/or their spouses, companions or family members. This information is tracked and aggregated at the brokerage firm or company level. The total value is divided by the total number of active contracts or policies in place with that firm for that year except for items relating directly to a specific customer or customers (which are reported to the specific customer(s)). This allocation is reported on the Schedule A reports for all ERISA customers who are part of a given broker firm's book of business.

Before submitting the Schedule A with your annual report to the Employee Benefits Security Administration, in addition to the information MetLife has provided, you should enter in the Schedule the appropriate name of the plan, three-digit plan number and employer identification number in the appropriate spaces immediately preceding Part I.

You may also wish to consult with your counsel concerning any need for attaching an opinion by an independent qualified public accountant.

This letter, together with your copy of the complete annual report should be retained for at least the 6-year period required by ERISA.

* The Gross Dealer Concession is based on premiums received and represents the total compensation and fees paid by the Insurance Company to the selling firm for the coverage used to fund the plan. Your representative(s) received payments subject to selling agreements that they have with the selling firm. The remaining compensation is used by the distributor or selling firm to pay other expenses, including Management Compensation, Conference expenses, etc. The Gross Dealer Concession includes the Commission Paid which is listed separately. The Metropolitan Life Insurance Company attests that the foregoing statement is complete and accurate to the best of its knowledge, information, and belief.

If you have any questions please contact your MetLife Account Representative:

DANIEL MOTA, +1 (813)673-3785 or 800-ASK-4-MET and MetLife will assist you in obtaining this information.

MetLife appreciates your business.



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.

► **File as an attachment to Form 5500**
► Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2024

**This Form is Open to
Public Inspection.**

For calendar plan year 2024 or fiscal plan year beginning 11/01/2024 , and ending 10/31/2025

A Name of plan	B Three digit plan number ►	
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIA	D Employer Identification Number	

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions
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Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit can be reported on a single Schedule A

1 Coverage:

(a) Name of insurance carrier

METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0215166	162,220	11/01/2024	10/31/2025

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part 1.

Totals *

Total amount of commissions paid	Total Fees Paid / amount
814,616	248,909

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. V7.2 Schedule A (Form 5500) 2024

Part II

Official Use Only



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

Name: JUSTWORKS INSURANCE SERVICES

Address: 55 WATER ST FL 29

City: NEW YORK ST: NY ZIP: 10041-0007

Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
Temporary Disability	814,616	Base Commissions	Temporary Disability	248,909	Supplemental Compensation	03
	814,616	Sub-total		248,909	Sub-total	

[illegible]

Official Use Only

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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. 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.

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 & 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 N/A**10 Nonexperience-rated contracts**

	Coverage	Amount
	Temporary Disability	16,150,925
a Total premiums or subscription charges paid to carrier		16,150,925
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, item 2 above, report amount		
Specify nature of costs below ▶		

Footnote(s)

The approximate number of persons covered as shown on the first page of the Schedule A is MetLife's estimated view of participants, spouses and dependents at the end of the policy period. This estimation should be used for reporting purposes only.

If the plan named in Item A on the first page of Schedule A (the "Plan") retains the services of a broker, consultant, agent or third-party administrator (each an "Intermediary") for the Plan, MetLife may in addition to paying base commission provide additional compensation to the intermediary under various preferred broker and other compensation programs and expense reimbursement. Under such programs, an intermediary may qualify for additional compensation that may or may not be directly charged to the Plan. Such compensation may not be included in the amount listed in Item 2 on the first page of Schedule A. Please contact MetLife if you would like additional information or details.



February 6, 2026

ATTENTION: DAVID FEINBERG
JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIA
CHURCH STREET STATION, P.O. BOX 7119
NEW YORK, NY 10008

The Employee Retirement Income Security Act of 1974 ("ERISA") requires an annual financial report on employee welfare benefit plans and pension benefit plans which cover 100 or more participants at the beginning of the plan year and are subject to ERISA. The administrator of such a plan is required to file an annual report on I.R.S./DOL Form 5500, including the accompanying Schedule A, with the Employee Benefits Security Administration.

Your Metropolitan Life Insurance Company ("MetLife") employee welfare benefit plan may be subject to ERISA's annual reporting requirements and MetLife is therefore providing you with the information needed to complete Schedule A of Form 5500. The attached report is not an actual Schedule A form and should not be attached to the Form 5500 for regulatory filing. The information should be forwarded to the person who will be completing your annual filing. The information is taken from the data MetLife maintains within its normal business records and is, to the best of MetLife's knowledge and belief, complete and accurate.

Part I, Section 2 of this report lists the compensation paid to intermediaries related to your plan. Intermediaries may include brokers, consultants, agents and third-party administrators. There are several categories of compensation that may be paid to an intermediary. For your reference, the categories of compensation are listed below.

- Base Commissions - Base commissions are generally paid to an intermediary on a monthly basis and are usually calculated as a percentage of premium. Base commissions are typically factored into the cost of the customer's plan.
- Supplemental Compensation - Supplemental compensation may be paid to qualifying intermediaries based on an intermediary's new business or total inforce premium for a specified year. It is not MetLife's practice to specifically factor supplemental compensation into the cost of customer's plan. Supplemental compensation is factored into the price structure of MetLife's institutional business products.
- Fees - Fees may include payments made to intermediaries for services such as administration, communication, enrollment, billing, eligibility, recordkeeping, printing and mailing. Fees may be directly charged to the customer's plan.
- Award - If your intermediary received an award (such as travel or a gift) from MetLife, MetLife allocated the value of the award to all plans that were considered in the qualification criteria proportionately.

Note, the non-monetary compensation amount included in the Schedule A, Fees Paid section of the enclosed report is based on the calendar year tracking of all individual gifts or items of non-monetary compensation such as dinners, tickets for shows or other entertainment events, membership dues, hotels, equal to or greater than \$10, that are given to or provided directly or indirectly to brokers, producers, and other insurance intermediaries and/or their spouses, companions or family members. This information is tracked and aggregated at the brokerage firm or company level. The total value is divided by the total number of active contracts or policies in place with that firm for that year except for items relating directly to a specific customer or customers (which are reported to the specific customer(s)). This allocation is reported on the Schedule A reports for all ERISA customers who are part of a given broker firm's book of business.

Before submitting the Schedule A with your annual report to the Employee Benefits Security Administration, in addition to the information MetLife has provided, you should enter in the Schedule the appropriate name of the plan, three-digit plan number and employer identification number in the appropriate spaces immediately preceding Part I.

You may also wish to consult with your counsel concerning any need for attaching an opinion by an independent qualified public accountant.

This letter, together with your copy of the complete annual report should be retained for at least the 6-year period required by ERISA.

* The Gross Dealer Concession is based on premiums received and represents the total compensation and fees paid by the Insurance Company to the selling firm for the coverage used to fund the plan. Your representative(s) received payments subject to selling agreements that they have with the selling firm. The remaining compensation is used by the distributor or selling firm to pay other expenses, including Management Compensation, Conference expenses, etc. The Gross Dealer Concession includes the Commission Paid which is listed separately. The Metropolitan Life Insurance Company attests that the foregoing statement is complete and accurate to the best of its knowledge, information, and belief.

If you have any questions please contact your MetLife Account Representative:

DANIEL MOTA, +1 (813)673-3785 or 800-ASK-4-MET and MetLife will assist you in obtaining this information.

MetLife appreciates your business.

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**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.

- **File as an attachment to Form 5500**
- Insurance companies are required to provide this information
pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2024

**This Form is Open to
Public Inspection.**

For calendar plan year 2024 or fiscal plan year beginning **11/01/2024** , and ending **10/31/2025**

A Name of plan	B Three digit plan number ►	
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIA	D Employer Identification Number	

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 can be reported on a single Schedule A

1 Coverage:

(a) Name of insurance carrier

METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0214990	235,584	11/01/2024	10/31/2025

- 2** Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part 1.

Totals *

Total amount of commissions paid	Total Fees Paid / amount
1,333,171	106,868

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. V7.2 Schedule A (Form 5500) 2024

Part II

Official Use Only

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

Name: JUSTWORKS INSURANCE SERVICES

Address: 55 WATER ST FL 29

City: NEW YORK ST: NY ZIP: 10041-0007

Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
Temporary Disability	515,839	Base Commissions	Temporary Disability	52,971	Supplemental Compensation	03
Long Term Disability	366,932	Base Commissions	LIFE	22,710	Supplemental Compensation	
LIFE	337,742	Base Commissions	Long Term Disability	17,354	Supplemental Compensation	
Vision	60,952	Base Commissions	Vision	8,031	Supplemental Compensation	
AD&D	51,706	Base Commissions	AD&D	5,802	Supplemental Compensation	
	1,333,171	Sub-total		106,868	Sub-total	

[illegible]

Official Use Only

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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. 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.

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 & 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) ► ADD									

9 Experience-rated contracts

N/A

10 Nonexperience-rated contracts

Coverage	Amount
Temporary Disability	10,582,990
Long Term Disability	7,179,136
LIFE	6,717,965
Vision	2,078,231
AD&D	1,057,570
a Total premiums or subscription charges paid to carrier	27,615,892
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, item 2 above, report amount	

Specify nature of costs below ►

Footnote(s)

The approximate number of persons covered as shown on the first page of the Schedule A is MetLife's estimated view of participants, spouses and dependents at the end of the policy period. This estimation should be used for reporting purposes only.

If the plan named in Item A on the first page of Schedule A (the "Plan") retains the services of a broker, consultant, agent or third-party administrator (each an "Intermediary") for the Plan, MetLife may in addition to paying base commission provide additional compensation to the Intermediary under various preferred broker and other compensation programs and expense reimbursement. Under such programs, an Intermediary may qualify for additional compensation that may or may not be directly charged to the Plan. Such compensation may not be included in the amount listed in Item 2 on the first page of Schedule A. Please contact MetLife if you would like additional information or details.

March 2, 2026

ATTENTION: DAVID FEINBERG
JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIA
CHURCH STREET STATION, P.O. BOX 7119
NEW YORK, NY 10008

The Employee Retirement Income Security Act of 1974 ("ERISA") requires an annual financial report on employee welfare benefit plans and pension benefit plans which cover 100 or more participants at the beginning of the plan year and are subject to ERISA. The administrator of such a plan is required to file an annual report on I.R.S./DOL Form 5500, including the accompanying Schedule A, with the Employee Benefits Security Administration.

Your Metropolitan Life Insurance Company ("MetLife") employee welfare benefit plan may be subject to ERISA's annual reporting requirements and MetLife is therefore providing you with the information needed to complete Schedule A of Form 5500. The attached report is not an actual Schedule A form and should not be attached to the Form 5500 for regulatory filing. The information should be forwarded to the person who will be completing your annual filing. The information is taken from the data MetLife maintains within its normal business records and is, to the best of MetLife's knowledge and belief, complete and accurate.

Part I, Section 2 of this report lists the compensation paid to intermediaries related to your plan. Intermediaries may include brokers, consultants, agents and third-party administrators. There are several categories of compensation that may be paid to an intermediary. For your reference, the categories of compensation are listed below.

- Base Commissions - Base commissions are generally paid to an intermediary on a monthly basis and are usually calculated as a percentage of premium. Base commissions are typically factored into the cost of the customer's plan.
- Supplemental Compensation - Supplemental compensation may be paid to qualifying intermediaries based on an intermediary's new business or total inforce premium for a specified year. It is not MetLife's practice to specifically factor supplemental compensation into the cost of customer's plan. Supplemental compensation is factored into the price structure of MetLife's institutional business products.
- Fees - Fees may include payments made to intermediaries for services such as administration, communication, enrollment, billing, eligibility, recordkeeping, printing and mailing. Fees may be directly charged to the customer's plan.
- Award - If your intermediary received an award (such as travel or a gift) from MetLife, MetLife allocated the value of the award to all plans that were considered in the qualification criteria proportionately.

Note, the non-monetary compensation amount included in the Schedule A, Fees Paid section of the enclosed report is based on the calendar year tracking of all individual gifts or items of non-monetary compensation such as dinners, tickets for shows or other entertainment events, membership dues, hotels, equal to or greater than \$10, that are given to or provided directly or indirectly to brokers, producers, and other insurance intermediaries and/or their spouses, companions or family members. This information is tracked and aggregated at the brokerage firm or company level. The total value is divided by the total number of active contracts or policies in place with that firm for that year except for items relating directly to a specific customer or customers (which are reported to the specific customer(s)). This allocation is reported on the Schedule A reports for all ERISA customers who are part of a given broker firm's book of business.

Before submitting the Schedule A with your annual report to the Employee Benefits Security Administration, in addition to the information MetLife has provided, you should enter in the Schedule the appropriate name of the plan, three-digit plan number and employer identification number in the appropriate spaces immediately preceding Part I.

You may also wish to consult with your counsel concerning any need for attaching an opinion by an independent qualified public accountant.

This letter, together with your copy of the complete annual report should be retained for at least the 6-year period required by ERISA.

* The Gross Dealer Concession is based on premiums received and represents the total compensation and fees paid by the Insurance Company to the selling firm for the coverage used to fund the plan. Your representative(s) received payments subject to selling agreements that they have with the selling firm. The remaining compensation is used by the distributor or selling firm to pay other expenses, including Management Compensation, Conference expenses, etc. The Gross Dealer Concession includes the Commission Paid which is listed separately. The Metropolitan Life Insurance Company attests that the foregoing statement is complete and accurate to the best of its knowledge, information, and belief.

If you have any questions please contact your MetLife Account Representative:

DANIEL MOTA, +1 (813)673-3785 or 800-ASK-4-MET and MetLife will assist you in obtaining this information.

MetLife appreciates your business.

**SCHEDULE A
(Form 5500)**Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance InformationThis schedule is required to be filed under section 104 of the
Employee Retirement Income Security Act of 1974.► **File as an attachment to Form 5500**► Insurance companies are required to provide this information
pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024**This Form is Open to
Public Inspection.**For calendar plan year 2024 or fiscal plan year beginning **11/01/2024**, and ending **10/31/2025**

A Name of plan	B Three digit plan number ►	
C Plan sponsor's name as shown on line 2a of Form 5500 JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIA	D Employer Identification Number	

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 can be reported on a single Schedule A

1 Coverage:

(a) Name of insurance carrier

METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0235676	60,888	11/01/2024	10/31/2025

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part 1.**Totals ***

Total amount of commissions paid	Total Fees Paid / amount
1,063,272	114,311

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. V7.2 Schedule A (Form 5500) 2024

Part II

Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid						
Name: JUSTWORKS INSURANCE SERVICES						
Address: 55 WATER ST FL 29			City: NEW YORK		ST: NY	ZIP: 10041-0007
Commissions Paid			Fees Paid			Organization
Coverage	Amount	Purpose	Coverage	Amount	Purpose	code
Dental	1,063,272	Base Commissions	Dental	114,311	Supplemental Compensation	03
	1,063,272	Sub-total		114,311	Sub-total	

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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. 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.

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 & 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	35,628,215	
(2) Increase (decrease) in amount due but unpaid	0	
(3) Increase (decrease) in unearned premium reserve	0	
(4) Earned ((1) + (2) - (3))		35,628,215
b Benefit charges: (1) Claims paid	28,658,827	
(2) Increase (decrease) in claim reserves	1,535	
(3) Incurred claims (add (1) and (2))		28,660,362
(4) Claims charged		28,660,362
c Remainder of premium: (1) Retention charges (on an accrual basis)--		
(A) Commissions	1,063,272	
(B) Administrative service or other fees	0	
(C) Other specific acquisition costs	0	
(D) Other expenses	1,805,738	
(E) Taxes	664,485	
(F) Charges for risks or other contingencies	712,564	
(G) Other retention charges	(9,996)	
(H) Total retention		4,236,063
(2) Dividends or retroactive rate refunds. These amounts were: ☒ paid in cash, or ☐ credited		2,731,790
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		0
(2) Claim reserves		2,092,094
(3) Other reserves		1,781,411
e Dividends or retroactive rate refunds due. (Do not include amount entered in c (2).)		

10 Nonexperience-rated contracts

N/A

Footnote(s)

If the plan named in Item A on the first page of Schedule A (the "Plan") retains the services of a broker, consultant, agent or third-party administrator (each an "Intermediary") for the Plan, MetLife may in addition to paying base commission provide additional compensation to the Intermediary under various preferred broker and other compensation programs and expense reimbursement. Under such programs, an Intermediary may qualify for additional compensation that may or may not be directly charged to the Plan. Such compensation may not be included in the amount listed in Item 2 on the first page of Schedule A. Please contact MetLife if you would like additional information or details.



January 22, 2026

**JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIATES
55 WATER STREET, 29TH FLOOR
NEW YORK, NY, 10041**

Dear Valued Customer:

Employee Retirement Income Security Act of 1974 (ERISA)

We have enclosed information that you may need for completing the 5500 Form Schedule A. This information reflects compensation paid to your agent or consultant for the plan year that recently ended for the coverages you have with us.

We are reporting any base commissions, bonuses and other types of compensation paid in relation to the plan during the plan year. Please note that only base commissions are included in the specific calculation of your premium or administrative service fee. Bonus and other non-base commission payments are not directly included in the determination of your premium or administrative service fee. Bonus payments may be based on the recipient's combined block of business and are allocated to cases according to their contribution to the amount earned.

IMPORTANT NOTE: The enclosed information may be divided into two reports. Some customers may receive a 5500 Addendum Report in addition to the standard 5500 Schedule A report form. The 5500 Addendum Report itemizes bonus compensation and payments that were processed manually separately. **If you have received the 5500 Addendum Report as well as the standard 5500 Schedule A report form, you will need to add the amounts in the Total line of the 5500 Addendum Report to the amount found in the standard 5500 Schedule A report form.**

Should you have any questions related to this information, please contact your agent, consultant, or the UnitedHealthcare Strategic Account Executive assigned to your case.

I hereby certify that to the best of my knowledge, information or belief at this time, and based upon information provided by duly authorized personnel, the foregoing statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate.

Thank you.

Sincerely,
The United Healthcare Team

Schedule A (Form 5500) Parts I and III
Insurance Information Certified by Carrier
Department of Labor Pension and Welfare Benefits

Principal Address:
55 WATER STREET, 29TH FLOOR
NEW YORK, NY, 10041

A Name of Plan: JUSTWORKS EMPLOYMENT GROUP LLC AND ITS PEO AFFILIATES

Part I Information Concerning Insurance Contract Coverage, Fee, and Commissions

1. Coverage

(a) Name of Insurance carrier: UnitedHealthcare Insurance Company

(b) EIN: 36-2739571 (c) NAIC code: 79413 (d) Contract or identification number: 1662634

(e) Approximate number of persons covered at the end of policy or contract year: * 15,505

* If the policy holder determines that they have a more accurate count, they should use their figure.

Policy or Contract year (f) From: November 1, 2024 (g) To: October 31, 2025

2. Insurance fees and commissions paid to agents, brokers, and other persons

Totals	Total amount of commissions Paid: \$0.00	Total fees paid / amount: \$0.00
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(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid:

(b) Amount of commissions paid: \$0.00 (c) Fees paid / Amount: NONE (d) Fees paid / Purpose: N/A
(e) Organizational Code: 3

Part III Welfare Benefit Contract Information

7. Benefit and contract type

(a) Health

9. Non experience-rated contracts:

(a) Total premiums or subscription charges paid to carrier: \$63,445,559.12

(b) Additional costs incurred by carrier, service, or other
Organization not reported in Part 1, item 2 above:

Specify Nature of cost: This special request report covers with the following customer number's information totaled in the premiums, commissions, and other pertinent information:

1663814, 1663642, 1729453, 1698477, 1698484, 1729465, 1663712, 1698485, 1663989, 1664081, 1698473, 1663679, 1663755, 1663834, 1663744, 1663697, 1663761, 1663898, 1698479, 1698474, 1698478, 1663503, 1663858, 1663824, 1664060, 1663625, 1663902, 1663485, 1664046, 1663698, 1664085, 1698481, 1663526, 1663534, 1663565, 1664033, 1663884, 1663830, 1663864, 1663896, 1663545, 1663787, 1663788, 1663903, 1663726, 1663694, 1663550, 1663762, 1663800, 1663732, 1663765, 1663643, 1663967, 1664070, 1663767, 1663950, 1663734, 1663701, 1663985, 1663933, 1663914, 1663612, 1663746, 1663620, 1663607, 1663748, 1663641, 1663648, 1663617, 1663516, 1663633, 1663737, 1663945, 1663990, 1663490, 1663518, 1663764, 1663488, 1663589, 1663517, 1663512, 1663685, 1663860, 1663500, 1663741, 1663804, 1663529, 1663540, 1663877, 1663754, 1663524, 1663710, 1663918, 1663506, 1663530, 1663501, 1664071, 1663969, 1729450, 1663778, 1663981, 1663994, 1663891, 1664059, 1663999, 1664001, 1663600, 1664012, 1664027, 1663995, 1664079, 1664005, 1663644, 1663908, 1663939, 1663976, 1663672, 1663766, 1663947, 1663699, 1663504, 1663801, 1668104, 1663924, 1663645, 1663665, 1663733, 1663639, 1663720, 1663992, 1663706, 1663962, 1663678, 1664077, 1663980, 1663532, 1663963, 1663861, 1664042, 1664043, 1663537, 1663937, 1729456, 1663874, 1663829, 1664025, 1663509, 1663651, 1663794, 1663539, 1663727, 1664052, 1663993, 1664022, 1663856, 1663951, 1664078, 1664063, 1698486, 1663996, 1664082, 1663965, 1663889, 1664031, 1698426, 1664066, 1663927, 1663520, 1663925, 1663708, 1663491, 1663899, 1663926, 1664000, 1663844, 1698447, 1664024, 1663952, 1664083, 1663771, 1664051, 1663544, 1663502, 1663654, 1663738, 1663956, 1663493,

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