

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 2025 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025	
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 PREFIX CORPORATION
1b	Three-digit plan number (PN) ▶ 501
1c	Effective date of plan 01/01/2022
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) PREFIX CORPORATION PREFIX CORPORATION PREFIX CORPORATION 1400 S LIVERNOIS ROCHESTER HILLS, MI 48307-3362 1400 S LIVERNOIS ROCHESTER HILLS, MI 48307-3362
2b	Employer Identification Number (EIN) 38-2334997
2c	Plan Sponsor's telephone number 248-650-1330
2d	Business code (see instructions) 541330

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.	05/18/2026	ERIN RAE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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	5 144
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) 144 6a(2) 136 6b 6c 6d 136 6e 6f 136 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 Characteristic Codes in the instructions:

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

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

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

a Pension Schedules

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

b General Schedules

- (1) ☐ **H** (Financial Information)
- (2) ☐ **I** (Financial Information – Small Plan)
- (3) ☒ **A** (Insurance Information) – Number Attached 9
- (4) ☒ **C** (Service Provider Information)
- (5) ☐ **D** (DFE/Participating Plan Information)
- (6) ☐ **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2025 Form M-1 annual report. If the plan was not required to file the 2025 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025	
A Name of plan PREFIX CORPORATION	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 PREFIX CORPORATION	D Employer Identification Number (EIN) 38-2334997

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 COMPANION LIFE					
(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
57-0523959	77828	CLI-SUM20381-00	136	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid 37217	(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 ASR CORPORATION 618 KENMOOR AVE SE SUITE 200 GRAND RAPIDS, MI 49546

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
37217			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	

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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	

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	265839
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 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025		
A Name of plan PREFIX CORPORATION	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 PREFIX CORPORATION	D Employer Identification Number (EIN) 38-2334997	

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 RELiance STANDARD					
(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
36-0883760	68381	LTD 129619	182	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid 1582	(b) Total amount of fees paid 395
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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	
STEALTH PARTNER GROUP LLC	18700 N HAYDEN RD SCOTTSDALE, AZ 85255

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
669			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
MACQUEEN & ASSOCIATES LLC	2191 TWELVE MILE ROAD BERKLEY, MI 48072

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1582	395		3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☐ 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)	15821	
(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)	15821
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)	2251	
(B) Administrative service or other fees	9c(1)(B)	395	
(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)	2646
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025	
A Name of plan PREFIX CORPORATION	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 PREFIX CORPORATION	D Employer Identification Number (EIN) 38-2334997

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 RELIANCE STANDARD					
(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
36-0883760	68381	G 166086	182	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid 4012	(b) Total amount of fees paid 1003
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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	
MACQUEEN & ASSOCIATES LLC	2191 TWELVE MILE ROAD BERKLEY, MI 48072

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4012	1003		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
STEALTH PARTNER GROUP LLC	18700 N HAYDEN RD SUITE 405 SCOTTSDALE, AZ 85255

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1732	0		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	

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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)	40121	
(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)	40121
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)	5744	
(B) Administrative service or other fees	9c(1)(B)	1003	
(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)	6747
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025	
A Name of plan PREFIX CORPORATION	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 PREFIX CORPORATION	D Employer Identification Number (EIN) 38-2334997

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 RELIANCE STANDARD					
(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
36-0883760	68381	VAR 207781	187	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid 747	(b) Total amount of fees paid 128
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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	
MACQUEEN & ASSOCIATES LLC	2191 TWELVE MILE ROAD BERKLEY, MI 48072

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
514	128		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
STEALTH PARTNER GROUP LLC	18700 N HAYDEN RD SCOTTSDALE, AZ 85255

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
206			3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☐ 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)	5149	
(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)	5149
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)	720	
(B) Administrative service or other fees	9c(1)(B)	206	
(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)	926
(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	849
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	
Specify nature of costs.		

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500. ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025		
A Name of plan PREFIX CORPORATION	B Three-digit plan number (PN) ►	501
C Plan sponsor's name as shown on line 2a of Form 5500 PREFIX CORPORATION	D Employer Identification Number (EIN) 38-2334997	

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 RELIANCE STANDARD					
(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
36-0883760	68381	GL 158431	182	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid 8252	(b) Total amount of fees paid 1457
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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	
MACQUEEN & ASSOCIATES LLC	2191 TWELVE MILE ROAD BERKLEY, MI 48072

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5828	1457		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
STEALTH PARTNER GROUP LLC	18700 N HAYDEN RD SCOTTSDALE, AZ 85255

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2424			3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☐ 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)	58285	
(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)	58285
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)	8252	
(B) Administrative service or other fees	9c(1)(B)	1457	
(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)	9709
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025		
A Name of plan PREFIX CORPORATION	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 PREFIX CORPORATION	D Employer Identification Number (EIN) 38-2334997	

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
DELTA DENTAL OF MICHIGAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
38-1791480	54305	3738	188	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid 3522	(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
MACQUEEN & ASSOCIATES LLC
2191 TWELVE MILE ROAD
BERKLEY, MI 48072

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3522			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)	69436	
(2) Increase (decrease) in amount due but unpaid	9a(2)	606	
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))	9a(4)		70042
b Benefit charges (1) Claims paid	9b(1)	58385	
(2) Increase (decrease) in claim reserves	9b(2)	-286	
(3) Incurred claims (add (1) and (2))	9b(3)		58099
(4) Claims charged	9b(4)		58099
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)	3522	
(B) Administrative service or other fees	9c(1)(B)	6017	
(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)	2801	
(G) Other retention charges	9c(1)(G)		
(H) Total retention	9c(1)(H)		12340
(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)		1187
(3) Other reserves	9d(3)		
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	9e		

10 Nonexperience-rated contracts:

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

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025		
A Name of plan PREFIX CORPORATION	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 PREFIX CORPORATION	D Employer Identification Number (EIN) 38-2334997	

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
DELTA DENTAL OF MICHIGAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
38-1791480	54305	8254	66	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid 699	(b) Total amount of fees paid 31
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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
MACQUEEN & ASSOCIATES LLC
2191 TWELVE MILE ROAD
BERKLEY, MI 48072

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	31		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)	14424	
(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)	14424
b Benefit charges (1) Claims paid	9b(1)	5530	
(2) Increase (decrease) in claim reserves	9b(2)	68	
(3) Incurred claims (add (1) and (2))		9b(3)	5598
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)	699	
(B) Administrative service or other fees	9c(1)(B)	1265	
(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)	577	
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	2541
(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)	224
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

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

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025		
A Name of plan PREFIX CORPORATION	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 PREFIX CORPORATION	D Employer Identification Number (EIN) 38-2334997	

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
HERITAGE VISION PLANS 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
38-2084788	11204	4083	122	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid 1431	(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
MACQUEEN & ASSOCIATES LLC
2191 TWELVE MILE ROAD
BERKLEY, MI 48072

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1431			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	
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 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025		
A Name of plan PREFIX CORPORATION	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 PREFIX CORPORATION	D Employer Identification Number (EIN) 38-2334997	

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
PROCARE RX

(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
58-2422694	68381	500003330-01	135	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
	10650

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
MACQUEEN & ASSOCIATES LLC
2191 TWELVE MILE ROAD
BERKLEY, MI 48072

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	10650		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)		273219
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	273219
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2025
		This Form is Open to Public Inspection.
For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025		
A Name of plan PREFIX CORPORATION	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 PREFIX CORPORATION	D Employer Identification Number (EIN) 38-2334997	

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

- a** Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. ☐ Yes ☒ No
- b** If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
ASR CORPORATION	618 KENMOOR AVE SE SUITE 200 GRAND RAPIDS, MI 49546 38-2651185
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	

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

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

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

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

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

ASR CORPORATION

618 KENMOOR AVE SE SUITE 200
GRAND RAPIDS, MI 49546

38-2651185

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	THIRD PARTY ADMIN	111628	Yes ☐ No ☒	Yes ☐ No ☒		Yes ☐ No ☐

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

EHIM

26711 NORTHWESTERN HWY SUITE 50
SOUTHFIELD, MI 48033

58-2422694

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	PHARMACY MANAGEMENT	10650	Yes ☐ No ☒	Yes ☐ No ☒		Yes ☐ No ☐

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

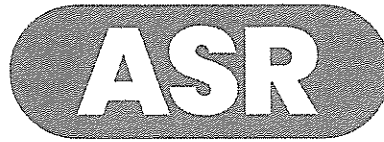
Explanation:

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

Explanation:

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

Explanation:



March 23, 2025

Erin Rae
Prefix Corporation
1400 S Livernois Rd
Rochester Hills, MI 48307

RE: Form 5500 and Related Materials

Dear Ms. Rae:

ASR Health Benefits is sending you information to assist you in completing the Annual Report (Form 5500), Insurance Information (Schedule A), and Service Provider Information (Schedule C) for your health and welfare plan(s). You must file a Form 5500 for each employer health and welfare plan funded with 100 or more participating employees at the beginning of a plan year. Also, if the plan is funded through a trust, a Form 5500 is required regardless of the number of participating employees.

If the plan provides one or more fully insured benefits, you must include a Schedule A from each insurer. Formerly, for self-funded health and welfare plans, a Schedule C was required with respect to each service provider who was paid \$5000 or more during the plan year. The new 5500 instructions now limit the Schedule C requirement to self-funded plans with a trust. Therefore, self-funded health and welfare plans funded through the employer's general assets no longer must complete a Schedule C with respect to service provider fees. If a plan is fully insured, is self-funded without a trust, or is a combination of these two, and has fewer than 100 participating employees at the beginning of a plan year, the plan is exempt from the Form 5500 requirement. If this exemption does not apply and a Form 5500 is required, you must file it within seven months after the plan year ends. However, you can file for a two-and-one-half-month extension of the filing deadline.

As a reminder, if you file a Form 5500 with respect to a health and welfare plan, you are also required to provide participants with a Summary Annual Report (SAR) regarding the plan (The SAR is a fill-in-the-blank summary of the plan's financial condition. A copy of a standard SAR is enclosed.). However, self-funded health and welfare plans with no trust are exempt from the SAR requirement, regardless of the number of participating employees. If an SAR is required, you must distribute it to participants no later than nine months after the plan year ends or two months after the end of the extension period if you filed for an extension with regard to the Form 5500.

If you have any questions, please contact Susie Bessey at (616) 957-1751, extension 3066.

Sincerely,

Susie Bessey
Billing & Enrollment Supervisor

Enclosures

FORM 5500 INFORMATION

The following information is provided to assist you in preparing Schedule A and Schedule C of Form 5500.

General Information

Name of Plan Sponsor:	Prefix Corporation
Address of Plan Sponsor:	1400 South Livernois Road Rochester Hills, Michigan 48307
Name of Plan:	Health Benefit Plan for Prefix Corporation
Type of Plan:	Welfare Plan
Three-Digit ERISA Plan Number:	501
Effective Date of Plan:	January 1, 2024
Plan Year:	January 1, 2025 – December 31, 2025
Total Number of Participants at the Beginning of the Plan Year:	144
Total Number of Participants at the end of the Plan Year:	136
Active:	
Retired or Separated Receiving Benefits:	
Retired or Separated Entitled to Future Benefits:	

Insurance Information (Schedule A)

Type of Benefit:	Stop-loss
Name of Insurance Carrier:	Companion Life
EIN of Insurance Carrier:	57-0523959
NAIC Code:	77828
Contract / Identification Number:	CLI-SUM20381-00
Approximate Number of Persons Covered at the end of the Contract Year:	136
Policy or Contract Year:	January 1, 2025 to December 31, 2025
Gross Premium Amount for Contract Year Paid to Carrier:	\$265,839.00
Insurance Fees and Commissions	
Paid to:	ASR Corporation
Total Commissions Paid:	\$37,217.46

Insurance Fees and Commissions , continued	
Total Fees Paid:	N/A
Purpose of Fees:	Placement of Stop-loss Insurance
Organization Code:	3

Service Provider Information (Schedule C)

Administrative Services	
Service Provider:	ASR Health Benefits
EIN of Service Provider:	38-2651185
NAIC Code:	524292
Official Plan Position:	Third-Party Administration
Fees / Commissions Paid:	\$111,628.50
Nature of Service Code:	13
Utilization Review Fees	
Service Provider:	N/A
EIN of Service Provider:	
Official Plan Position:	Utilization Review
Fees / Commissions Paid:	
Nature of Service Code:	13
PPO Provider	
Service Provider:	N/A
EIN of Service Provider:	
Official Plan Position:	Preferred Provider Network
Fees / Commissions Paid:	
Nature of Service Code:	13

SUMMARY ANNUAL REPORT FOR (NAME OF PLAN)

This is a summary of the annual report of the (name of plan, EIN, Plan Number) for the period (plan year summarized). The annual report has been filed with the U.S. Department of Labor's Pension and Welfare Benefits Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

[If self-insured, include the following] (Name of employer) has committed itself to pay certain claims under the terms of the plan.

Insurance Information

The plan has a contract(s) with (name of insurance carrier[s]) to pay (name types of benefit claims) claims incurred under the terms of the plan. The total premiums paid for the plan year ending () were \$.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report (Note: List only those items which are actually included in the latest annual report):

1. an accountant's report
2. assets held for investments
3. fiduciary information, including non-exempt transactions between the plan and parties-in-interest (that is, persons who have certain relationships with the plan)
4. loans or other obligations in default or classified as uncollectible
5. leases in default or classified as uncollectible
6. transactions in excess of 5% of the plan assets
7. insurance information, including sales commissions paid by insurance carriers
8. financial information and information on payments to service providers
9. information regarding any common or collective trusts, pooled separate accounts, master trusts, or 103-12 investment entities in which the plan participates

To obtain a copy of the full annual report, or any part thereof, write or call the office of (your company's name, business address, and telephone number). The charge to cover copying costs will be (\$) for the full annual report or (\$) per page for any part of the report.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the plan, (your company's name, business address, and telephone number), and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-5638, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2025 This Form is Open to Public Inspection
--	---	---

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025	
A Name of plan PREFIX CORPORATION 1300 NORTH HAMLIN ROAD, SUITE 100 ROCHESTER HILLS MI 48309	B Three-digit plan number (PN) ▶
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number(EIN)

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:	HERITAGE VISION PLANS 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
38-2084788	11204	CLIENT ID:4083-00 GROUP ID:1086	122 SUBSCRIBERS 226 TOTAL	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
\$1,431.10	\$0.00

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
--

MACQUEEN INSURANCE GROUP 415 S. WEST STREET ROYAL OAK, MI 48067
--

(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	

December 11, 2025

**INSURANCE INFORMATION
FORM 5500 - SCHEDULE A**

PREFIX CORPORATION
1400 S. Livernois Road
Rochester Hills, MI 48307

EIN: 36-0883760
NAIC: 68381
ORG. NUMBER: 3

Policyholder Name: Prefix Corporation
Policy Number: VAR 207781
Policy Type: ACCIDENTAL DEATH AND DISMEMBERMENT
Number of Covered Employees: 187
Policy Contract Year: 12/1/2024 to 11/30/2025

PREMIUM							
Benefits	Premium	Rate 1	Eff	Rate 2	Eff	Rate 3	Eff
Voluntary AD&D	\$5,149.21	0.9999	00/00	0.0000	00/00	0.0000	00/00
Total Premium:	\$5,149.21						

COMPENSATION*			
Payee Code: 35-2280		Total Commission:	\$514.92
Payee Name: MacQueen & Associates LLC		Total Administrative and Other Fees:	\$128.71
Payee Address: 2191 Twelve Mile Rd Berkley, MI 48072		Total Amount of Compensation:	\$643.63
Payee Code: 70-9652		Total Commission:	\$206.21
Payee Name: Stealth Partner Group, LLC		Total Administrative and Other Fees:	\$0.00
Payee Address: 18700 N. Hayden Rd Suite 405 Scottsdale, AZ 85255		Total Amount of Compensation:	\$206.21

RG0: MICHIGAN



*Compensation includes, but is not limited to the following: commissions, benefit administration fees, premier/elite producer payments and administrative fees.

December 11, 2025

TO OUR GROUP POLICYHOLDERS WITH 100 OR MORE PLAN PARTICIPANTS

RE: EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

(1) ANNUAL REPORT OF WELFARE BENEFIT PLAN - FORM 5500

(2) SUMMARY ANNUAL REPORT

- (1) Section 104 of ERISA requires that each Plan Administrator who maintains a welfare benefit Plan subject to ERISA having 100 or more participants at any time during the plan year must file an annual report with the Department of Labor. The report must be filed within 7 months of the end of the plan year. Certain failures are provided for failure to comply.

As it appears your plan is subject to the Act, the data on the enclosed form is provided for your assistance in completing your annual report. By supplying this information it is not our intent to advise you as to your legal obligations under the act, nor do we wish to imply that this information constitutes all of the data to be included in our annual report.

If you expect to file an annual report, you would normally receive a complete copy of form 5500 and Schedule A from the Department of Labor, with all necessary instructions, prior to the filing date. Follow the instructions carefully. If you or your legal counsel have questions, please contact The Labor-Management Services Administration Office at the Department of Labor.

- (2) Section 104(B) of ERISA requires a plan administrator who must file an annual report to also furnish a Summary Annual Report to each plan participant and beneficiary within 9 months of the end of your plan year and without charge.

The Summary Annual Report should include the following information:

1. The name of the plan as determined by your Plan Document and, if different, the name by which the plan is commonly known to its participants and beneficiaries; and
2. The name and business address (do not use P.O. Box number) of the Plan Sponsor (usually the employer to whom the policy was issued). However, if different, show:
 - a. The name and address of any employer having employees covered by the plan; or
 - b. The name and address of any labor organization maintaining the plan; or
 - c. In case of a plan established or maintained by two or more employers or by one or more employers and one or more employee organizations, the name and address of the association, committee, joint board of trustees, parent, or most significant employer of a group of employees contributing to the same plan; and
3. The name, business address, (do not use P.O. Box number) and business telephone number of the Plan Administrator; and
4. A statement of assets and liabilities stated at current value; and
5. Separate or combined statements of income and expenses and changes in net assets; and
6. Such other materials as are necessary to fairly summarize the Annual Report.
7. A notice which says, for example: Plan participants and beneficiaries may obtain copies of the Annual Report filed with the Department of Labor by making a written request to the Plan Administrator. A reasonable charge will be made; or you may inspect the report without charge at the office of (give name and address, usually the Plan Administrators; or if the plan covers participants at various locations, you may be required to have a copy available at each location. If so, list the locations).

The above information with respect to the contents of the Summary Annual Report is based on our interpretation of the Act. It is not our intention to advise you as to your obligations regarding compliance under the Act. We suggest that you consult with your own legal counsel and discuss the requirements before any action is taken.

Customer Service
1-800-644-1103

ERISA-11



December 11, 2025

**INSURANCE INFORMATION
FORM 5500 - SCHEDULE A**

PREFIX CORPORATION
1400 S. Livernois Road
Rochester Hills, MI 48307

EIN: 36-0883760
NAIC: 68381
ORG. NUMBER: 3

Policyholder Name: Prefix Corporation
Policy Number: G 166086
Policy Type: WEEKLY INCOME
Number of Covered Employees: 182
Policy Contract Year: 12/1/2024 to 11/30/2025

PREMIUM							
Benefits	Premium	Rate 1	Eff	Rate 2	Eff	Rate 3	Eff
Short Term Disability	\$40,121.63	0.1850	12/24	0.1610	12/23	0.0000	00/00
Total Premium:	\$40,121.63						

COMPENSATION*			
Payee Code: 35-2280		Total Commission:	\$4,012.18
Payee Name: MacQueen & Associates LLC		Total Administrative and Other Fees:	\$1,003.06
Payee Address: 2191 Twelve Mile Rd Berkley, MI 48072		Total Amount of Compensation:	\$5,015.24
Payee Code: 70-9652		Total Commission:	\$1,732.68
Payee Name: Stealth Partner Group, LLC		Total Administrative and Other Fees:	\$0.00
Payee Address: 18700 N. Hayden Rd Suite 405 Scottsdale, AZ 85255		Total Amount of Compensation:	\$1,732.68

RGO: MICHIGAN



*Compensation includes, but is not limited to the following: commissions, benefit administration fees, premier/elite producer payments and administrative fees.

December 11, 2025

TO OUR GROUP POLICYHOLDERS WITH 100 OR MORE PLAN PARTICIPANTS

RE: EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

(1) ANNUAL REPORT OF WELFARE BENEFIT PLAN - FORM 5500

(2) SUMMARY ANNUAL REPORT

- (1) Section 104 of ERISA requires that each Plan Administrator who maintains a welfare benefit Plan subject to ERISA having 100 or more participants at any time during the plan year must file an annual report with the Department of Labor. The report must be filed within 7 months of the end of the plan year. Certain failures are provided for failure to comply.

As it appears your plan is subject to the Act, the data on the enclosed form is provided for your assistance in completing your annual report. By supplying this information it is not our intent to advise you as to your legal obligations under the act, nor do we wish to imply that this information constitutes all of the data to be included in our annual report.

If you expect to file an annual report, you would normally receive a complete copy of form 5500 and Schedule A from the Department of Labor, with all necessary instructions, prior to the filing date. Follow the instructions carefully. If you or your legal counsel have questions, please contact The Labor-Management Services Administration Office at the Department of Labor.

- (2) Section 104(B) of ERISA requires a plan administrator who must file an annual report to also furnish a Summary Annual Report to each plan participant and beneficiary within 9 months of the end of your plan year and without charge.

The Summary Annual Report should include the following information:

1. The name of the plan as determined by your Plan Document and, if different, the name by which the plan is commonly known to its participants and beneficiaries; and
2. The name and business address (do not use P.O. Box number) of the Plan Sponsor (usually the employer to whom the policy was issued). However, if different, show:
 - a. The name and address of any employer having employees covered by the plan; or
 - b. The name and address of any labor organization maintaining the plan; or
 - c. In case of a plan established or maintained by two or more employers or by one or more employers and one or more employee organizations, the name and address of the association, committee, joint board of trustees, parent, or most significant employer of a group of employees contributing to the same plan; and
3. The name, business address, (do not use P.O. Box number) and business telephone number of the Plan Administrator; and
4. A statement of assets and liabilities stated at current value; and
5. Separate or combined statements of income and expenses and changes in net assets; and
6. Such other materials as are necessary to fairly summarize the Annual Report.
7. A notice which says, for example: Plan participants and beneficiaries may obtain copies of the Annual Report filed with the Department of Labor by making a written request to the Plan Administrator. A reasonable charge will be made; or you may inspect the report without charge at the office of (give name and address, usually the Plan Administrators; or if the plan covers participants at various locations, you may be required to have a copy available at each location. If so, list the locations).

The above information with respect to the contents of the Summary Annual Report is based on our interpretation of the Act. It is not our intention to advise you as to your obligations regarding compliance under the Act. We suggest that you consult with your own legal counsel and discuss the requirements before any action is taken.

Customer Service
1-800-644-1103

ERISA-11



BC1 5500 = 'G'



166086 00000101

ProCare Rx

Financial Information requested:

Company Number: 50003330-01

Company Name: Prefix Corporation

Date range of required information: 1/1/2025 - 12/31/2025

EIN: 58-2422694 ProCare Rx

Total Rx Cost: \$273,219.86

Total Number of Claims Processed: 5,399

Total EHIM Administrative Fee: \$10,650.50

Total Agent Commission: \$0.00

End of Year Head Count: 135

Data for ERISA, Schedule A, Form 5500 reporting

form placement	item name	value
1a	Insurance Carrier	Delta Dental of Michigan
1b	EIN	38-1791480
1c	NAIC	54305
1d	Contract or identification number	3738
1e	Persons covered at period end	188
1f	Reported from	01-JAN-2025
1g	Reported to	31-DEC-2025
2a	Total amount of commissions paid to all service providers	\$3,522.17
2b	Total amount of fees paid to all service providers	\$145.00
3a	agent/agency 1	MacQueen & Associates, LLC--Scott MacQueen
3a	agent/agency 1	2191 12 MILE RD
3a	agent/agency 1	BERKLEY, MI 48072
3b	Total amount of sales and base commissions 1	\$0.00
3c	Aggregate amount of fees and other commissions 1	\$145.00
3d	Purpose of fees and other commissions 1	Retention Bonus
3e	agent/agency 1	3
3a	agent/agency 2	MacQueen & Associates, LLC--Scott MacQueen
3a	agent/agency 2	2191 TWELVE MILE RD
3a	agent/agency 2	BERKLEY, MI 48072
3b	Total amount of sales and base commissions 2	\$1,236.11
3c	Aggregate amount of fees and other commissions 2	\$0.00
3e	agent/agency 2	3
3a	agent/agency 3	MacQueen & Associates, LLC--Scott MacQueen
3a	agent/agency 3	415 S WEST ST STE 350
3a	agent/agency 3	ROYAL OAK, MI 48067
3b	Total amount of sales and base commissions 3	\$2,286.06
3c	Aggregate amount of fees and other commissions 3	\$0.00
3e	agent/agency 3	3
8b	Benefit and contract type	Dental
9a/1	Amount received	\$69,435.13
9a/2	Change in amount due	\$606.98
9a/4	Premiums earned	\$70,042.11
9b/1	Claims paid	\$58,385.90
9b/2	Change in claim reserve	\$-286.46
9b/3	Incurred claims	\$58,099.44
9c/1/A	Commissions	\$3,522.17
9c/1/B	Admin service or other fee	\$6,017.55
9c/1/E	Taxes	\$0.00
9c/1/F	Charges for risk or contingencies	\$2,801.68
9c/1/H	Total retention	\$12,341.40
9d/2	Claim reserves	\$1,187.10

December 11, 2025

**INSURANCE INFORMATION
FORM 5500 - SCHEDULE A**

PREFIX CORPORATION
1400 S. Livernois Road
Rochester Hills, MI 48307

EIN: 36-0883760
NAIC: 68381
ORG. NUMBER: 3

Policyholder Name: Prefix Corporation
Policy Number: GL 158431
Policy Type: GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT
Number of Covered Employees: 182
Policy Contract Year: 12/1/2024 to 11/30/2025

Benefits	PREMIUM						
	Premium	Rate 1	Eff	Rate 2	Eff	Rate 3	Eff
Basic AD&D	\$3,313.66	0.0200	12/24	0.0200	12/23	0.0000	00/00
Basic Life	\$19,384.97	0.1170	12/24	0.1170	12/23	0.0000	00/00
Dependent Life	\$5,462.23	0.3510	01/23	0.0000	00/00	0.0000	00/00
Supplemental Life	\$30,124.96	0.9999	00/00	0.0000	00/00	0.0000	00/00
Total Premium:	\$58,285.82						

COMPENSATION*			
Payee Code: 35-2280		Total Commission:	\$5,828.64
Payee Name: MacQueen & Associates LLC		Total Administrative and Other Fees:	\$1,457.14
Payee Address: 2191 Twelve Mile Rd Berkley, MI 48072		Total Amount of Compensation:	\$7,285.78
Payee Code: 70-9652		Total Commission:	\$2,424.64
Payee Name: Stealth Partner Group, LLC		Total Administrative and Other Fees:	\$0.00
Payee Address: 18700 N. Hayden Rd Suite 405 Scottsdale, AZ 85255		Total Amount of Compensation:	\$2,424.64

RG0: MICHIGAN



*Compensation includes, but is not limited to the following: commissions, benefit administration fees, premier/elite producer payments and administrative fees.

December 11, 2025

TO OUR GROUP POLICYHOLDERS WITH 100 OR MORE PLAN PARTICIPANTS

RE: EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)
(1) ANNUAL REPORT OF WELFARE BENEFIT PLAN - FORM 5500
(2) SUMMARY ANNUAL REPORT

- (1) Section 104 of ERISA requires that each Plan Administrator who maintains a welfare benefit Plan subject to ERISA having 100 or more participants at any time during the plan year must file an annual report with the Department of Labor. The report must be filed within 7 months of the end of the plan year. Certain failures are provided for failure to comply.

As it appears your plan is subject to the Act, the data on the enclosed form is provided for your assistance in completing your annual report. By supplying this information it is not our intent to advise you as to your legal obligations under the act, nor do we wish to imply that this information constitutes all of the data to be included in our annual report.

If you expect to file an annual report, you would normally receive a complete copy of form 5500 and Schedule A from the Department of Labor, with all necessary instructions, prior to the filing date. Follow the instructions carefully. If you or your legal counsel have questions, please contact The Labor-Management Services Administration Office at the Department of Labor.

- (2) Section 104(B) of ERISA requires a plan administrator who must file an annual report to also furnish a Summary Annual Report to each plan participant and beneficiary within 9 months of the end of your plan year and without charge.

The Summary Annual Report should include the following information:

1. The name of the plan as determined by your Plan Document and, if different, the name by which the plan is commonly known to its participants and beneficiaries; and
2. The name and business address (do not use P.O. Box number) of the Plan Sponsor (usually the employer to whom the policy was issued). However, if different, show:
 - a. The name and address of any employer having employees covered by the plan; or
 - b. The name and address of any labor organization maintaining the plan; or
 - c. In case of a plan established or maintained by two or more employers or by one or more employers and one or more employee organizations, the name and address of the association, committee, joint board of trustees, parent, or most significant employer of a group of employees contributing to the same plan; and
3. The name, business address, (do not use P.O. Box number) and business telephone number of the Plan Administrator; and
4. A statement of assets and liabilities stated at current value; and
5. Separate or combined statements of income and expenses and changes in net assets; and
6. Such other materials as are necessary to fairly summarize the Annual Report.
7. A notice which says, for example: Plan participants and beneficiaries may obtain copies of the Annual Report filed with the Department of Labor by making a written request to the Plan Administrator. A reasonable charge will be made; or you may inspect the report without charge at the office of (give name and address, usually the Plan Administrators; or if the plan covers participants at various locations, you may be required to have a copy available at each location. If so, list the locations).

The above information with respect to the contents of the Summary Annual Report is based on our interpretation of the Act. It is not our intention to advise you as to your obligations regarding compliance under the Act. We suggest that you consult with your own legal counsel and discuss the requirements before any action is taken.

Customer Service
1-800-644-1103

ERISA-11



BC1 5500 = 'GL'



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Data for ERISA, Schedule A, Form 5500 reporting

form placement	item name	value
1a	Insurance Carrier	Delta Dental of Michigan
1b	EIN	38-1791480
1c	NAIC	54305
1d	Contract or identification number	8254
1e	Persons covered at period end	66
1f	Reported from	01-JAN-2025
1g	Reported to	31-DEC-2025
2a	Total amount of commissions paid to all service providers	\$699.32
2b	Total amount of fees paid to all service providers	\$31.25
3a	agent/agency 1	MacQueen & Associates, LLC--Scott MacQueen
3a	agent/agency 1	2191 12 MILE RD
3a	agent/agency 1	BERKLEY, MI 48072
3b	Total amount of sales and base commissions 1	\$0.00
3c	Aggregate amount of fees and other commissions 1	\$31.25
3d	Purpose of fees and other commissions 1	Retention Bonus
3e	agent/agency 1	3
3a	agent/agency 2	MacQueen & Associates, LLC--Scott MacQueen
3a	agent/agency 2	2191 TWELVE MILE RD
3a	agent/agency 2	BERKLEY, MI 48072
3b	Total amount of sales and base commissions 2	\$232.39
3c	Aggregate amount of fees and other commissions 2	\$0.00
3e	agent/agency 2	3
3a	agent/agency 3	MacQueen & Associates, LLC--Scott MacQueen
3a	agent/agency 3	415 S WEST ST STE 350
3a	agent/agency 3	ROYAL OAK, MI 48067
3b	Total amount of sales and base commissions 3	\$466.93
3c	Aggregate amount of fees and other commissions 3	\$0.00
3e	agent/agency 3	3
8b	Benefit and contract type	Dental
9a/1	Amount received	\$14,424.03
9a/2	Change in amount due	\$0.00
9a/4	Premiums earned	\$14,424.03
9b/1	Claims paid	\$5,530.00
9b/2	Change in claim reserve	\$68.67
9b/3	Incurred claims	\$5,598.67
9c/1/A	Commissions	\$699.32
9c/1/B	Admin service or other fee	\$1,265.24
9c/1/E	Taxes	\$0.00
9c/1/F	Charges for risk or contingencies	\$576.96
9c/1/H	Total retention	\$2,541.52
9d/2	Claim reserves	\$224.60