Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110
1210-0089

2025

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 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
HELFMAN ENTERPRISES, INC. COMPREHENSIVE WELFARE BENEFIT PLAN

1b Three-digit plan number (PN) ▶ 504

1c Effective date of plan 01/01/2017

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)
HELFMAN ENTERPRISES, INC.

7720 KATY FREEWAY
HOUSTON, TX 77024

2b Employer Identification Number (EIN)
74-2200964

2c Plan Sponsor's telephone number
713-533-6222

2d Business code (see instructions)
441110

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.	07/03/2026	TAYLOR NEESE
	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 [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

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

a Sponsor's name

4b EIN

c Plan Name

4d PN

5	Total number of participants at the beginning of the plan year	**5**	326
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	326
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	348
b	Retired or separated participants receiving benefits	**6b**	3
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	351
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

4A 4B 4D 4E 4F 4Q

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

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

A Name of plan
HELFMAN ENTERPRISES, INC. COMPREHENSIVE WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 504

C Plan sponsor's name as shown on line 2a of Form 5500
HELFMAN ENTERPRISES, INC.

D Employer Identification Number (EIN)
74-2200964

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
AETNA LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
06-6033492	60054	870585-SL	231	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

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

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

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

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

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

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

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

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

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	(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	

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

b	Balance at the end of the previous year			7b	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
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)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

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** [X] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	0
(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)	0
(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	1643541
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

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

A Name of plan
HELFMAN ENTERPRISES, INC. COMPREHENSIVE WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 504

C Plan sponsor's name as shown on line 2a of Form 5500
HELFMAN ENTERPRISES, INC.

D Employer Identification Number (EIN)
74-2200964

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
GUARDIAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5123390	64246	00418965	297	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
19973	2921

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

THE BALDWIN GROUP SOUTHWEST, LLC
5151 SAN FELIPE 24TH FLOOR
HOUSTON, TX 77056

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
19117	2921	FEES PAID	3

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

WATCHTOWER BENEFITS LLC
2734 N MILDRED AVE #3
CHICAGO, IL 60618

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
856			3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

b	Balance at the end of the previous year			7b	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
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)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

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** [X] Dental
- **c** [X] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	0
(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)	0
(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	191170
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

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

A Name of plan
HELFMAN ENTERPRISES, INC. COMPREHENSIVE WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 504

C Plan sponsor's name as shown on line 2a of Form 5500
HELFMAN ENTERPRISES, INC.

D Employer Identification Number (EIN)
74-2200964

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
COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
57-0144607	62049	E5170667,ET AL.	258	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
76122	1622

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

COLONIAL LIFE INDIVIDUAL BROKERS
POST OFFICE BOX 1365
COLUMBIA, SC 29202

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
76122	1622	FEES PAID	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	

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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	

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

b	Balance at the end of the previous year			7b	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
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)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

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** [X] Life insurance
- **e** [X] 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** [X] Other (specify) ▶ ACCIDENT, CRITICAL ILLNESS AND SPECIFIC DISEASE COMPONENTS

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	0
(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)	0
(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	511109
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 [X] No

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

Colonial Life & Accident Insurance Company
Post Office Box 1365
Columbia, SC 29202-1365

Colonial Life

Helfman Dodge 12
Attn: Melissa Burks
7720 Katy Freeway
Houston, TX 77024

000796 E5170642000000 004 000

February 12, 2026

Re: Information Schedule A (Form 5500)
BCN: E5170642

Dear Melissa Burks:

Colonial Life & Accident Insurance Company is pleased to certify the enclosed Schedule A information on your Colonial Life insurance products.

This Schedule A information is forwarded to you for use by your Plan Administrator in completing your annual report Form 5500 if your company is required to file this form. Colonial Life takes no position as to whether or not your insurance program constitutes a "Welfare Benefit Plan" under the ERISA Act of 1974. The enclosed report shows producer compensation information, including earned commissions and bonuses. Bonuses and non cash incentives are reported as "Amount of Fees Paid, If Any." The report also contains premium paid information and the approximate number of covered persons.

Colonial Life's premium paid information may differ from your records due to timing of posting payments, timing of employee payroll changes, and our internal business practices related to the application of premium. For this reason we suggest you use premium information from your records for reporting "Premium Paid to Carrier."

For more information on reporting requirements or assistance in completing the Form 5500, call the EFAST helpline at 1-866-463-3278. The form and additional information can also be accessed at www.efast.dol.gov. Consult your company attorney or other advisors if you have any questions regarding your obligation to file a Form 5500. For questions regarding the enclosed information, please contact Service Operations at 1-800-256-7004, option 1.

We appreciate this opportunity to serve you.

Sincerely,

Service Operations Department

Insurance Data for Schedule A Form 5500

AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 THE COMPENSATION DATA IS PROVIDED TO COMPLY WITH VARIOUS REGULATIONS, REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

Name of Carrier: Colonial Life & Accident Insurance Company
Post Office Box 1365
Columbia, SC 29202-1365

Carrier EIN: 57-0144607
Carrier NAIC Code: 62049

Account Name: Helfman Dodge 12
Billing Control Number: E5170642
Plan Year Date Range: 01/01/2025 - 12/31/2025

Organization Code For Agents/Producers: 3

Amount for Pre-tax or Employer Paid Premium:	$43,863.96
Amount for After Tax Paid Premium:	$123,283.21
Total Paid Premium:	$167,147.17

APPROXIMATE NUMBER OF PERSONS COVERED IN DECEMBER 2025: 94

Insurance Fees and Commission Information for Schedule A Form 5500

Agent/Producer Name Address	Amount of Commissions On Pre-Tax Or Employer Paid Policies	Amount of Commissions On After Tax Or Employee Paid Policies	Total Commissions Paid	Amount of Fees Paid If Any
Santiago Ochoa 3605 S Lombard Ave Cicero IL 60804	$8.74	$107.47	$116.21	$0.00
Beth R Peterson 14315 Overbrook Ln Houston TX 77077	$108.78	$335.48	$444.26	$0.00
Mark Charles Morgan 1880 S Dairy Ashford Rd Ste 53 Houston TX 77077	$11.26	$79.60	$90.86	$0.00
Leroy Phelps 102 Bent Tree Dr Boerne TX 78006	$11.36	$21.82	$33.18	$0.38

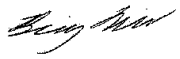
Agent/Producer Name Address	Amount of Commissions On Pre-Tax Or Employer Paid Policies	Amount of Commissions On After Tax Or Employee Paid Policies	Total Commissions Paid	Amount of Fees Paid If Any
Sonya Ann Lenihan 19026 Azalea Glen Ct Houston TX 77084	$1,207.72	$3,354.70	$4,562.42	$6.01
Andrea James 26203 Ginger Gables Ln 53 Katy TX 77494	-$0.15	$0.61	$0.46	$0.00
Patricia M Phelps 102 Bent Tree Dr Boerne TX 78006	$11.36	$21.82	$33.18	$0.00
Kurt W Braeutigam 11219 Chestnut River Ln Cypress TX 77433	$4,191.57	$13,606.16	$17,797.73	$0.00
Michael Anthony Chandler 9839 Common Law Converse TX 78109	$6.93	$1.54	$8.47	$0.00
Darin Potts 100 Detering St Apt 2128 Houston TX 77007	$247.16	$761.83	$1,008.99	$529.96
Jessica Christine Leard Po Box 264 Riceville IA 50466	$94.32	$139.48	$233.80	$0.00
Debra Jean Humphrey 1325 Mardi Ln Houston TX 77055	$29.77	$88.49	$118.26	$0.00
Debra Kay Gapp 20302 Stone Falls Ct Cypress TX 77433	$29.74	$179.25	$208.99	$33.29
Robert Armando Rodriguez 11403 Barker Cypress Rd Ste J Cypress TX 77433	$0.00	$0.95	$0.95	$0.00

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Agent/Producer Name Address	Amount of Commissions On Pre-Tax Or Employer Paid Policies	Amount of Commissions On After Tax Or Employee Paid Policies	Total Commissions Paid	Amount of Fees Paid If Any
Grand Totals	$5,958.56	$18,699.20	$24,657.76	$569.64

Certification Statement

Colonial Life & Accident Insurance Company hereby certifies that the enclosed statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate.



Ben Quick
AVP of Sales Compensation

Colonial Life & Accident Insurance Company
Post Office Box 1365
Columbia, SC 29202-1365

Colonial Life

Helfman Ford Inc
Attn: Lisa Rios/Belinda Guevara
12220 Southwest Freeway
Meadows Place, TX 77477

011836 E5138953000000 004 000

February 12, 2026

Re: Information Schedule A (Form 5500)
BCN: E5138953

Dear Lisa Rios/Belinda Guevara:

Colonial Life & Accident Insurance Company is pleased to certify the enclosed Schedule A information on your Colonial Life insurance products.

This Schedule A information is forwarded to you for use by your Plan Administrator in completing your annual report Form 5500 if your company is required to file this form. Colonial Life takes no position as to whether or not your insurance program constitutes a "Welfare Benefit Plan" under the ERISA Act of 1974. The enclosed report shows producer compensation information, including earned commissions and bonuses. Bonuses and non cash incentives are reported as "Amount of Fees Paid, If Any." The report also contains premium paid information and the approximate number of covered persons.

Colonial Life's premium paid information may differ from your records due to timing of posting payments, timing of employee payroll changes, and our internal business practices related to the application of premium. For this reason we suggest you use premium information from your records for reporting "Premium Paid to Carrier."

For more information on reporting requirements or assistance in completing the Form 5500, call the EFAST helpline at 1-866-463-3278. The form and additional information can also be accessed at www.efast.dol.gov. Consult your company attorney or other advisors if you have any questions regarding your obligation to file a Form 5500. For questions regarding the enclosed information, please contact Service Operations at 1-800-256-7004, option 1.

We appreciate this opportunity to serve you.

Sincerely,

Service Operations Department

Insurance Data for Schedule A Form 5500

AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 THE COMPENSATION DATA IS PROVIDED TO COMPLY WITH VARIOUS REGULATIONS, REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

Name of Carrier: Colonial Life & Accident Insurance Company
Post Office Box 1365
Columbia, SC 29202-1365

Carrier EIN: 57-0144607
Carrier NAIC Code: 62049

Account Name: Helfman Ford Inc
Billing Control Number: E5138953
Plan Year Date Range: 01/01/2025 - 12/31/2025

Organization Code For Agents/Producers: 3

Amount for Pre-tax or Employer Paid Premium:	$41,488.52
Amount for After Tax Paid Premium:	$104,318.83
Total Paid Premium:	$145,807.35

APPROXIMATE NUMBER OF PERSONS COVERED IN DECEMBER 2025: 72

Insurance Fees and Commission Information for Schedule A Form 5500

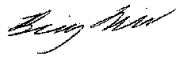
Agent/Producer Name Address	Amount of Commissions On Pre-Tax Or Employer Paid Policies	Amount of Commissions On After Tax Or Employee Paid Policies	Total Commissions Paid	Amount of Fees Paid If Any
Santiago Ochoa 3605 S Lombard Ave Cicero IL 60804	$6.48	$61.80	$68.28	$0.00
Beth R Peterson 14315 Overbrook Ln Houston TX 77077	$44.55	$198.22	$242.77	$0.00
Mark Charles Morgan 1880 S Dairy Ashford Rd Ste 53 Houston TX 77077	$21.27	$31.80	$53.07	$0.00
Leroy Phelps 102 Bent Tree Dr Boerne TX 78006	$24.65	$29.96	$54.61	$0.63

Agent/Producer Name Address	Amount of Commissions On Pre-Tax Or Employer Paid Policies	Amount of Commissions On After Tax Or Employee Paid Policies	Total Commissions Paid	Amount of Fees Paid If Any
Sonya Ann Lenihan 19026 Azalea Glen Ct Houston TX 77084	$1,164.04	$2,677.80	$3,841.84	$4.40
Andrea James 26203 Ginger Gables Ln 53 Katy TX 77494	$33.66	$50.45	$84.11	$0.00
Patricia M Phelps 102 Bent Tree Dr Boerne TX 78006	$24.65	$29.96	$54.61	$0.00
Kurt W Braeutigam 11219 Chestnut River Ln Cypress TX 77433	$4,014.13	$11,126.67	$15,140.80	$0.00
Darin Potts 100 Detering St Apt 2128 Houston TX 77007	$269.98	$583.25	$853.23	$428.43
Jessica Christine Leard Po Box 264 Riceville IA 50466	$17.34	$14.09	$31.43	$0.00
Debra Jean Humphrey 1325 Mardi Ln Houston TX 77055	$384.56	$383.82	$768.38	$0.00
Debra Kay Gapp 20302 Stone Falls Ct Cypress TX 77433	$166.33	$231.45	$397.78	$46.93
Robert Armando Rodriguez 11403 Barker Cypress Rd Ste J Cypress TX 77433	$9.92	$10.69	$20.61	$0.00
Grand Totals	$6,181.56	$15,429.96	$21,611.52	$480.39

011837 E5138953000000 004 001

Certification Statement

Colonial Life & Accident Insurance Company hereby certifies that the enclosed statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate.



Ben Quick
AVP of Sales Compensation

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Colonial Life & Accident Insurance Company
Post Office Box 1365
Columbia, SC 29202-1365

Colonial Life

Helfman River Oaks Crysler 12
Attn: J Katz/A Bradford
4807 Kirby Dr
Houston, TX 77098

000798 E5170667000000 004 000

February 12, 2026

Re: Information Schedule A (Form 5500)
BCN: E5170667

Dear J Katz/A Bradford:

Colonial Life & Accident Insurance Company is pleased to certify the enclosed Schedule A information on your Colonial Life insurance products.

This Schedule A information is forwarded to you for use by your Plan Administrator in completing your annual report Form 5500 if your company is required to file this form. Colonial Life takes no position as to whether or not your insurance program constitutes a "Welfare Benefit Plan" under the ERISA Act of 1974. The enclosed report shows producer compensation information, including earned commissions and bonuses. Bonuses and non cash incentives are reported as "Amount of Fees Paid, If Any." The report also contains premium paid information and the approximate number of covered persons.

Colonial Life's premium paid information may differ from your records due to timing of posting payments, timing of employee payroll changes, and our internal business practices related to the application of premium. For this reason we suggest you use premium information from your records for reporting "Premium Paid to Carrier."

For more information on reporting requirements or assistance in completing the Form 5500, call the EFAST helpline at 1-866-463-3278. The form and additional information can also be accessed at www.efast.dol.gov. Consult your company attorney or other advisors if you have any questions regarding your obligation to file a Form 5500. For questions regarding the enclosed information, please contact Service Operations at 1-800-256-7004, option 1.

We appreciate this opportunity to serve you.

Sincerely,

Service Operations Department

Insurance Data for Schedule A Form 5500

AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 THE COMPENSATION DATA IS PROVIDED TO COMPLY WITH VARIOUS REGULATIONS, REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

Name of Carrier: Colonial Life & Accident Insurance Company
Post Office Box 1365
Columbia, SC 29202-1365

Carrier EIN: 57-0144607
Carrier NAIC Code: 62049

Account Name: Helfman River Oaks Crysler 12
Billing Control Number: E5170667
Plan Year Date Range: 01/01/2025 - 12/31/2025

Organization Code For Agents/Producers: 3

Amount for Pre-tax or Employer Paid Premium:	$47,794.08
Amount for After Tax Paid Premium:	$150,360.72
Total Paid Premium:	$198,154.80

APPROXIMATE NUMBER OF PERSONS COVERED IN DECEMBER 2025: 92

Insurance Fees and Commission Information for Schedule A Form 5500

Agent/Producer Name Address	Amount of Commissions On Pre-Tax Or Employer Paid Policies	Amount of Commissions On After Tax Or Employee Paid Policies	Total Commissions Paid	Amount of Fees Paid If Any
Santiago Ochoa 3605 S Lombard Ave Cicero IL 60804	$12.96	$134.04	$147.00	$0.00
Beth R Peterson 14315 Overbrook Ln Houston TX 77077	$131.64	$243.97	$375.61	$0.00
Mark Charles Morgan 1880 S Dairy Ashford Rd Ste 53 Houston TX 77077	$8.16	$62.73	$70.89	$0.00
Leroy Phelps 102 Bent Tree Dr Boerne TX 78006	$4.34	$13.03	$17.37	$0.20

Agent/Producer Name Address	Amount of Commissions On Pre-Tax Or Employer Paid Policies	Amount of Commissions On After Tax Or Employee Paid Policies	Total Commissions Paid	Amount of Fees Paid If Any
Wayne James Pitrie 9737 Bevlyn Dr Houston TX 77025	$11.36	$64.31	$75.67	$4.46
Sonya Ann Lenihan 19026 Azalea Glen Ct Houston TX 77084	$1,467.04	$3,590.82	$5,057.86	$5.49
Andrea James 26203 Ginger Gables Ln 53 Katy TX 77494	$71.31	$78.96	$150.27	$0.00
Patricia M Phelps 102 Bent Tree Dr Boerne TX 78006	$4.34	$13.03	$17.37	$0.00
Kurt W Braeutigam 11219 Chestnut River Ln Cypress TX 77433	$4,903.47	$17,369.88	$22,273.35	$0.00
Darin Potts 100 Detering St Apt 2128 Houston TX 77007	$302.04	$774.49	$1,076.53	$513.54
Jessica Christine Leard Po Box 264 Riceville IA 50466	$10.71	$17.44	$28.15	$0.00
Debra Jean Humphrey 1325 Mardi Ln Houston TX 77055	$42.60	$77.33	$119.93	$0.00
Debra Kay Gapp 20302 Stone Falls Ct Cypress TX 77433	$141.93	$300.92	$442.85	$48.73
Grand Totals	$7,111.90	$22,740.95	$29,852.85	$572.42

000799 E5170667000000 004 001

Certification Statement

Colonial Life & Accident Insurance Company hereby certifies that the enclosed statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate.

Ben Quick
AVP of Sales Compensation

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