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
METLIFE BASIC LIFE 2025

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/2023

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

301 W 6TH ST
CHATTANOOGA, TN 37402-1108

301 W 6TH ST
CHATTANOOGA, TN 37402-1108

2b Employer Identification Number (EIN)
62-0475699

2c Plan Sponsor's telephone number
423-805-3304

2d Business code (see instructions)
713900

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.	07/22/2026	MICHAEL BAKER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/22/2026	MICHAEL BAKER
	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

METROPOLITAN LIFE INSURANCE COMPANY

501 US HIGHWAY 22 FL 2
BRIDGEWATER, NJ 08807-2441

3b Administrator's EIN: 13-5581829

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**	103
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)**	103
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	101
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	101
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	101
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:

4F 4H

9a Plan funding arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

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

A Name of plan
METLIFE BASIC LIFE 2025

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
YMCA OF METROPOLITAN CHATTANOOGA

D Employer Identification Number (EIN)
62-0475699

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

1 Coverage Information:

(a) Name of insurance carrier
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	TM05941715	101	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
4623	262

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

MARSH & MCLENNAN AGENCY LLC
6279 TRI RIDGE BLVD STE 400
LOVELAND, OH 45140-8320

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	10	MARKETING FEES	

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

MARSH & MCLENNAN
250 PEHLE AVE
STE 400 PARK 80 PLAZA 2
SADDLE BROOK, NJ 07663-5826

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	48	SUPPLEMENTAL COMPENSATION	

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

MCGRIFF INSURANCE SERVICES INC
PO BOX 896620
CHARLOTTE, NC 28289-6620

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
0	125	SUPPLEMENTAL COMPENSATION	

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

MCGRIFF A MARSH & MCLENNAN AGENCY
PO BOX 896620
CHARLOTTE, NC 28289-6620

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
732	53	NON-MONETARY COMPENSATION	

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

MCGRIFF INSURANCE SERVICES
PO BOX 896620
CHARLOTTE, NC 28289-6620

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
998	26	NON-MONETARY COMPENSATION	

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

CENTERSTONE INSURANCE AGENCY AND FI
PO BOX 664173
DALLAS, TX 75266-4173

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1163			

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

BENEFITMALL HOLDING INC DBA DKG INS
PO BOX 664173
DALLAS, TX 75266-4173

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1730	0		

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [X] Temporary disability (accident and sickness)
- **f** [X] 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**	15613
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**	7773

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. ▶

00241
Metropolitan Life Insurance Company
501 U.S. Highway 22, 2nd Floor - West
Bridgewater, NJ 08807

MetLife

Sales & Broker Compensation Services

March 25, 2026

0024100100200000000100000000000000000

YMCA OF METROPOLITAN CHATTANOOGA
301 W 6TH STREET
CHATTANOOGA, TN 37402

Re: Compensation Disclosure Statement

Metropolitan Life Insurance Company ("MetLife") recognizes the relationship you have with your broker and the important role your broker plays in helping you select the insurance carrier, policy, and level of coverage that is appropriate for your needs. MetLife is committed to disclosing to each of its group customers information about MetLife's compensation plans. The enclosed statement lists the types of compensation MetLife paid during the last plan year to your broker and/or certain service providers in relation to your company's group insurance plan.

- **Base commissions.** Base commissions are payable as a percentage of paid premium or a fixed dollar amount for as long as the broker is recognized by the customer and MetLife as the broker of record for your policy.
- **Supplemental compensation.** If your broker is eligible for supplemental compensation, these payments may range from 0% to 8% of premium. The actual percentage of supplemental compensation is determined each year and is based on: (1) the number of MetLife products sold or inforce through your broker during the previous year; (2) the amount of premium or fees with respect to MetLife products sold or inforce through your broker during the previous year; (3) the persistency percentage of products inforce through your broker during the previous year; (4) premium growth during the previous year; and/or (5) a fixed percentage of the premium for products as set by MetLife. The cost of supplemental compensation is not directly charged to the price of MetLife products, except as an allocation of overhead expense, which is applied to all eligible group insurance products. As a result, a customer's rates are unaffected whether or not the customer's broker receives supplemental compensation.
- **Service fees.** Service fees include payments made to a broker for services such as administration, communications, enrollment, billing, recordkeeping, printing, and mailing.
- **Additional compensation.** MetLife may pay your broker additional compensation based on the sale of multiple products. The cost of additional compensation is not directly charged to the price of MetLife products, except as an allocation of overhead expense, which is applied to all eligible group insurance products. As a result, a customer's rates are unaffected whether or not the customer's broker receives the additional compensation.
- **Other compensation authorized by you.** You may have authorized MetLife to pay compensation to a broker or other service provider and such compensation is reflected on the compensation statement.

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

More information about MetLife's compensation plans can be found on www.metlife.com/brokercompensation. Questions regarding broker compensation can be directed to ask4met@metlifeservice.com, or you may call (800) ASK 4MET.

Thank you for doing business with MetLife.

Metro olitan Life Insurance Com an

Com ensation Disclosure Statement

For policy year beginning 01/01/2025 **and ending** 12/31/2025

Customer Name: YMCA OF METROPOLITAN CHATTANOOGA

Polic Number: TM05941715

Name and address of the a ents brokers or other ersons to whom commissions fees or other com ensation were aid

Name: BENEFITMALL HOLDING INC D/B/A DKG INS & FIN SERVICES INC

Address: PO BOX 664173 Cit : DALLAS ST: TX ZIP: 75266-4173

Commissions Paid

Coverage	Amount	Purpose
Long Term Disability	1,148	Base Commissions
Temporary Disability	582	Base Commissions
	1,730	**Sub-total**

Fees Paid or Other Compensation

Coverage	Amount	Purpose
	0	**Sub-total**

Name: CENTERSTONE INSURANCE AGENCY AND FINANCIAL SERVICES

Address: PO BOX 664173 Cit : DALLAS ST: TX ZIP: 75266-4173

Commissions Paid

Coverage	Amount	Purpose
Long Term Disability	775	Base Commissions
Temporary Disability	388	Base Commissions
	1,163	**Sub-total**

Fees Paid or Other Compensation

Coverage	Amount	Purpose
	0	**Sub-total**

Name: MCGRIFF INSURANCE SERVICES INC

Address: PO BOX 896620 Cit : CHARLOTTE ST: NC ZIP: 28289-6620

Commissions Paid

Coverage	Amount	Purpose
Long Term Disability	663	Base Commissions
Temporary Disability	335	Base Commissions
	998	**Sub-total**

Fees Paid or Other Compensation

Coverage	Amount	Purpose
Multiple	26	Non-Monetary Compensation
	26	**Sub-total**

Name: MCGRIFF A MARSH & MCLENNAN AGENCY LLC

Address: PO BOX 896620 City: CHARLOTTE ST: NC ZIP: 28289-6620

Commissions Paid

Coverage	Amount	Purpose
Long Term Disability	485	Base Commissions
Temporary Disability	247	Base Commissions
	732	**Sub-total**

Fees Paid or Other Compensation

Coverage	Amount	Purpose
Multiple	53	Non-Monetary Compensation
	53	**Sub-total**

Name: MCGRIFF INSURANCE SERVICES INC

Address: PO BOX 896620 City: CHARLOTTE ST: NC ZIP: 28289-6620

Commissions Paid

Coverage	Amount	Purpose
	0	**Sub-total**

Fees Paid or Other Compensation

Coverage	Amount	Purpose
Long Term Disablility	84	Supplemental Compensation
Temporary Disability	41	Supplemental Compensation
	125	**Sub-total**

Name: MARSH & MCLENNAN

Address: 250 PEHLE AVE STE 400 PARK 80 PLAZA 2 City: SADDLE BROOK ST: NJ ZIP: 07663-5826

Commissions Paid

Coverage	Amount	Purpose
	0	**Sub-total**

Fees Paid or Other Compensation

Coverage	Amount	Purpose
Long Term Disability	32	Supplemental Compensation
Temporary Disability	16	Supplemental Compensation
	48	**Sub-total**

Name: MARSH & MCLENNAN AGENCY LLC

Address: 6279 TRI RIDGE BLVD STE 400 City: LOVELAND ST: OH ZIP: 45140-8320

Commissions Paid

Coverage	Amount	Purpose
	0	**Sub-total**

Fees Paid or Other Compensation

Coverage	Amount	Purpose
Multiple	10	Marketing Fees
	10	**Sub-total**

Total amount of Commissions paid	Total amount of Fees paid or Other Compensation
4,623	262

Footnotes:
The commissions and fees reported have been aggregated at a total coverage level.