

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 03/01/2025 and ending 02/28/2026	
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 CH EMPLOYMENT SERVICES LLC 2025
1b	Three-digit plan number (PN) ▶ 501
1c	Effective date of plan 03/01/2025
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) CH EMPLOYMENT SERVICES LLC 2025 CH EMPLOYMENT SERVICES, LLC. CRESCENT HEIGHTS - EDGARDO VEGA 2200 BISCAYNE BLVD MIAMI, FL 33137-5283 2200 BISCAYNE BLVD MIAMI, FL 33137-5283
2b	Employer Identification Number (EIN) 32-0050913
2c	Plan Sponsor's telephone number 305-374-5700
2d	Business code (see instructions) 531390

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.	08/07/2026	ARTURO DE LA VEGA
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	08/07/2026	ARTURO DE LA VEGA
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Filed with authorized/valid electronic signature.	08/07/2026	ARTURO DE LA VEGA
	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	5 215
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) 215 6a(2) 228 6b 0 6c 0 6d 228 6e 6f 228 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 4C 4D 4E 4F 4H 4J 4L

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

a Pension Schedules

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

b General Schedules

- (1)** ☐ **H** (Financial Information)
- (2)** ☐ **I** (Financial Information – Small Plan)
- (3)** ☒ **A** (Insurance Information) – Number Attached 12
- (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 03/01/2025 and ending 02/28/2026		
A Name of plan CH EMPLOYMENT SERVICES LLC 2025	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 CH EMPLOYMENT SERVICES LLC 2025	D Employer Identification Number (EIN) 32-0050913	

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
CIGNA HEALTH AND 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
59-1031071	67369	3340783	226	03/01/2025	02/28/2026

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	146825

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
ALL ATLANTIC BENEFITS LLC
200 S PARK ROAD SUITE 475
HOLLYWOOD, FL 33021

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	146825	BENEFIT ADVISOR PAYMENT	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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(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	

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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. 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	2669685
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 03/01/2025 and ending 02/28/2026	
A Name of plan CH EMPLOYMENT SERVICES LLC 2025	B Three-digit plan number (PN) ► 501
C Plan sponsor's name as shown on line 2a of Form 5500 CH EMPLOYMENT SERVICES LLC 2025	D Employer Identification Number (EIN) 32-0050913

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
CIGNA HEALTH AND 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
59-1031071	67369	3340783	207	03/01/2025	02/28/2026

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 12826	(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
ALL ATLANTIC BENEFITS LLC 200 S PARK ROAD SUITE 475 HOLLYWOOD, FL 33021

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
12826			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 (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below) ▶	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	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 (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below) ▶	7e(1)	
	7e(2)	
	7e(3)	
	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) ▶ **PREPAID DENTAL**

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	129595
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 03/01/2025 and ending 02/28/2026	
A Name of plan CH EMPLOYMENT SERVICES LLC 2025	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 CH EMPLOYMENT SERVICES LLC 2025	D Employer Identification Number (EIN) 32-0050913

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
CIGNA DENTAL OF CALIFORNIA, 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
59-2600475	67369	3340783	15	03/01/2025	02/28/2026

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 229	(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
ALL ATLANTIC BENEFITS LLC 200 S PARK ROAD SUITE 475 HOLLYWOOD, FL 33021

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
229			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
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(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	2292
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 03/01/2025 and ending 02/28/2026		
A Name of plan CH EMPLOYMENT SERVICES LLC 2025	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 CH EMPLOYMENT SERVICES LLC 2025	D Employer Identification Number (EIN) 32-0050913	

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 CIGNA DENTAL HEALTH OF FLORIDA, 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
59-1611217	52021	3340783	25	03/01/2025	02/28/2026

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 385	(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 ALL ATLANTIC BENEFITS LLC 200 S PARK ROAD SUITE 475 HOLLYWOOD, FL 33021

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
385			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	3847
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 03/01/2025 and ending 02/28/2026	
A Name of plan CH EMPLOYMENT SERVICES LLC 2025	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 CH EMPLOYMENT SERVICES LLC 2025	D Employer Identification Number (EIN) 32-0050913

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 CIGNA DENTAL HEALTH OF KENTUCKY, 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
59-2619589	52108	3340783	8	03/01/2025	02/28/2026

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 128	(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 ALL ATLANTIC BENEFITS LLC 200 S PARK ROAD SUITE 475 HOLLYWOOD, FL 33021

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

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

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
b ☒ Dental
c ☐ Vision
d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ Stop loss (large deductible)
j ☒ HMO contract
k ☐ PPO contract
l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	1282
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 03/01/2025 and ending 02/28/2026		
A Name of plan CH EMPLOYMENT SERVICES LLC 2025	B Three-digit plan number (PN) ►	501
C Plan sponsor's name as shown on line 2a of Form 5500 CH EMPLOYMENT SERVICES LLC 2025	D Employer Identification Number (EIN) 32-0050913	

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
CIGNA HEALTH AND 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
59-1031071	67369	3340783	176	03/01/2025	02/28/2026

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 2331	(b) Total amount of fees paid 0
--	------------------------------------

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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
ALL ATLANTIC BENEFITS LLC
200 S PARK ROAD SUITE 475
HOLLYWOOD, FL 33021

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2331			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	23307
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	

BENEFIT ADVISOR PAYMENTS

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 03/01/2025 and ending 02/28/2026	
A Name of plan CH EMPLOYMENT SERVICES LLC 2025	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 CH EMPLOYMENT SERVICES LLC 2025	D Employer Identification Number (EIN) 32-0050913

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 UNITED OF OMAHA 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
47-0322111	69868	G000AW5T	273	03/01/2025	02/28/2026

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 7472	(b) Total amount of fees paid 2872
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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	
UNITED BENEFIT ADVISORS OF FLORIDA	6885 BELFORT OAKS PL STE 210 JACKSONVILLE, FL 32216

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3259		AGENT OR BROKER OF RECORD	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
CENTRO BENEFITS GROUP LLC	325 N KIRKWOOD RD STE 300 KIRKWOOD, MT 63122

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	1404	OTHER COMPENSATION	3

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

ALL ATLANTIC BENEFITS LLC

200 S PARK ROAD SUITE 475
STE 300
HOLLYWOOD, MT 33021

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4213	1468	AGENT OR BROKER OF RECORD/OTHER COMPENSATION	3

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

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

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

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

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

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

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

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

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) ▶ AD&D

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	49812
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 03/01/2025 and ending 02/28/2026	
A Name of plan CH EMPLOYMENT SERVICES LLC 2025	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 CH EMPLOYMENT SERVICES LLC 2025	D Employer Identification Number (EIN) 32-0050913

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 UNITED OF OMAHA 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
47-0322111	69869	G000AW5T	273	03/01/2025	02/28/2026

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 8864	(b) Total amount of fees paid 3438
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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	
UNITED BENEFIT ADVISORS OF FLORIDA	6885 BELFORT OAKS PL STE 210 JACKSONVILLE, FL 32216

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3849	0	AGENT OR BROKER OF RECORD	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
CENTRO BENEFITS GROUP LLC	325 N KIRKWOOD RD STE 300 KIRKWOOD, MT 63122

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	1672	OTHER COMPENSATION	3

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

ALL ATLANTIC BENEFITS LLC

200 S PARK ROAD SUITE 475
HOLLYWOOD, FL 33021

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5015	1766	AGENT OR BROKER OF RECORD/OTHER COMPENSATION	3

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

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

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

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

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

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

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

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

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	59092
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 03/01/2025 and ending 02/28/2026	
A Name of plan CH EMPLOYMENT SERVICES LLC 2025	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 CH EMPLOYMENT SERVICES LLC 2025	D Employer Identification Number (EIN) 32-0050913

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 UNITED OF OMAHA 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
47-0322111	69868	G000AW5T	144	03/01/2025	02/28/2026

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 3930	(b) Total amount of fees paid 1530
--	---------------------------------------

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	
ALL ATLANTIC BENEFITS LLC	200 S PARK RD STE 475 HOLLYWOOD, FL 33021

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2261	776	AGENT OR BROKER OF RECORD/OTHER COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
UNITED BENEFIT ADVISORS OF FLORIDA	6885 BELFORT OAKS PL STE 210 JACKSONVILLE, FL 32216

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1669	0	AGENT OR BROKER OF RECORD	3

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

CENTRO BENEFITS GROUP LLC

325 N KIRKWOOD RD
STE 300
KIRKWOOD, MT 63122

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	754	OTHER COMPENSATION	3

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

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

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

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

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

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

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

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

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) ▶ **SHORT TERM DISABILITY VOLUNTARY**

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	26199
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 03/01/2025 and ending 02/28/2026	
A Name of plan CH EMPLOYMENT SERVICES LLC 2025	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 CH EMPLOYMENT SERVICES LLC 2025	D Employer Identification Number (EIN) 32-0050913

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 UNITED OF OMAHA 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
47-0322111	69868	G000AW5T	54	03/01/2025	02/28/2026

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 4514	(b) Total amount of fees paid 1765
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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	
ALL ATLANTIC BENEFITS LLC	200 S PARK RD STE 475 HOLLYWOOD, FL 33021

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2612	894	AGENT OR BROKER OF RECORD/OTHER COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
UNITED BENEFIT ADVISORS OF FLORIDA	6885 BELFORT OAKS PL STE 210 JACKSONVILLE, FL 32216

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1902	0	AGENT OR BROKER OF RECORDS	3

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

CENTRO BENEFITS GROUP LLC

325 N KIRKWOOD RD
STE 300
KIRKWOOD, MT 63122

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	871	OTHER COMPENSATION	3

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

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

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

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

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

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

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

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

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 (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below) ▶	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	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 (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below) ▶	7e(1)	
	7e(2)	
	7e(3)	
	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) ▶ **TERM LIFE - VOLUNTARY**

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	30098
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 03/01/2025 and ending 02/28/2026	
A Name of plan CH EMPLOYMENT SERVICES LLC 2025	B Three-digit plan number (PN) ► 501
C Plan sponsor's name as shown on line 2a of Form 5500 CH EMPLOYMENT SERVICES LLC 2025	D Employer Identification Number (EIN) 32-0050913

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 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	E4405189	175	03/01/2025	02/28/2026

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 41085	(b) Total amount of fees paid 7142
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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 VARIOUS AGENTS/PRODUCERS

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
41085	7142	CERTIFICATION STATEMENT	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) ▶ **ACCIDENTAL, HOSPITAL CONFINEMENT, CANCER, CRITICAL ILLNESS, LIFE**

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	184327
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 03/01/2025 and ending 02/28/2026		
A Name of plan CH EMPLOYMENT SERVICES LLC 2025	B Three-digit plan number (PN) ►	501
C Plan sponsor's name as shown on line 2a of Form 5500 CH EMPLOYMENT SERVICES LLC 2025	D Employer Identification Number (EIN) 32-0050913	

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
THE PAUL REVERE 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
04-1590994	67598	E4405189	4	03/01/2025	02/28/2026

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 805	(b) Total amount of fees paid 49
---	-------------------------------------

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
VARIOUS AGENTS/PRODUCERS

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
805	49	SALES COMPENSATION	3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

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

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance
e ☐ Temporary disability (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug
i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract
m ☒ Other (specify) ▶ **GROUP ACCIDENT, CANCER, GROUP HOSPITAL**

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	3781
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 Insurance Information					
Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator					
A. Plan Name		CH EMPLOYMENT SERVICES, LLC		B. Three-Digit Plan # (PN)	
C. Plan Sponsor's Name:		Plan will Provide		D. Company Identification Number:	
Plan will Provide		Plan will Provide		Plan will Provide	
Part I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)					
1. Coverage Information (a) Name of Insurance Carrier: Cigna Health and Life Insurance Company and affiliates ("Cigna")					
(b) EIN	(c) NAIC Code	(d) Contract or Identification Number	(e) Approx. no. of persons covered at end of policy or contract year	Policy/Contract Year (f) From (g) To	
59-1031071	67369	3340783	226 Employees	03/01/2025	02/28/2026
2. Insurance fees and commissions information. Enter total fees and commissions paid					
(a) Total Amount of commissions paid			(b) Total Amount of fees paid		
\$0			\$146,825		
3. Persons receiving commissions and fees.		Fees and commissions paid			
(a) Name and address of the agent, broker or other person to who commissions and fees were paid	(b) Amount of sales and base commissions paid	(c) Amount*	(d) Purpose*	(e) Organization code	
Non Experience - Rated		*Refer to footnotes for incentive \$\$ amounts and purpose as applicable			
ALL ATLANTIC BENEFITS LLC, 200 S PARK RD, STE 475, HOLLYWOOD, FL, 33021	\$0	\$146,825	Benefit Advisor Payments	3- Insurance Agent or Broker	
Part II Investment and Annuity Contract Information					
Outstanding Monies Due >			This section not applicable to this Plan		
\$0			contract number of identification > same as 1d		
Part III Welfare Benefit Contract Information					
If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where 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 information	(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 Unemploy	(h) ☐ Prescription drug	
	(i) ☐ Stop Loss (Large deductible)	(j) ☐ HMO contract	(k) ☐ PPO Contract	(l) ☒ Indemnity contract	
	(m) ☐ Other (Prepaid Dental)				
9. Experience-Rated Contracts This section not applicable for this Plan					
10. Nonexperience-rated contracts	(a) Total premiums or subscriptions charges paid to carrier				\$2,669,685
	Premium Due as of				06/22/2026
	(b) If the carrier, service or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount				\$0
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. > Answer "Not Applicable"					
Comments: ESTIMATED					
THE INFORMATION REFLECTED IN THIS REPORT IS ACCURATE AND COMPLETE BASED UPON INFORMATION AVAILABLE TO CIGNA HEALTHCARE COMPANIES AT THE TIME THIS REPORT IS PREPARED AND IS CERTIFIED AS BEING COMPLETE AND ACCURATE.					
NOTE TO POLICYHOLDERS: You may have responsibilities under law to determine whether the information contained in this report could be used to identify individuals either when combined with other information that you have or in any other manner and, if so, to take appropriate protective steps.					



Schedule A Insurance Information - Footnotes					
Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator					
A. Plan Name		CH EMPLOYMENT SERVICES, LLC		B. Three-Digit Plan #(PN)	
C. Plan Sponsor's Name:		Plan will Provide		D. Company Identification Number:	
Part I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)					
1. Coverage Information (a) Name of Insurance Carrier: Cigna Health and Life Insurance Company and affiliates ("Cigna")					
(b) EIN 59-1031071	(c) NAIC Code 67369	(d) Contract or Identification Number 3340783	(e) Approx.no.of persons covered at end of policy or contract year 226 Employees	Policy/Contract Year (f) From 03/01/2025 (g) To 02/28/2026	
Part I, line 1a: "Name of Insurance Carrier", (b) "EIN", (c) "NAIC Code" - The plan to which this report applies may be funded by contracts issued by more than one Cigna Healthcare company each of which is an "insurance carrier." The issuance of multiple insurance carrier contracts is necessary to cover individuals who participate in the same plan but reside in different geographic locations. As the Cigna Healthcare companies whose contracts fund the plan are grouped as a single unit by Cigna Healthcare for purposes of underwriting the plan, combining the information with respect to these individual contracts in this report will provide more meaningful insurance information for the Schedule A. The individual contracts of the Cigna Healthcare companies are grouped as a unit for purposes of this report. To reference individual contracts please refer to the Schedule A Appendix pages contained within this reporting package, if applicable. Part I, line 2a, 2b: The following amounts were paid to your broker(s) / consultant(s) during the contract year: Commissions: \$0 General Agent Fees: \$0 Benefit Advisor Fees: \$146,825 Part I, line 3c: Incentive compensation payments based upon persons/members in your plan and/or lump sum amount: \$0 (Broker and General Agents combined) attributable to your plan for the 2025 calendar year. These amounts are funded from Cigna companies general overhead. Contact your broker/consultant for further details. In addition to the Commissions/Benefit Advisor Fees reported, Cigna Healthcare enters into compensation programs under which certain agents and brokers provide our companies with market intelligence produce and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific policies, is funded from our general overhead, and is not required to be reported on Schedule A. Your agent or broker may also have participated at our expense, in events we sponsor to inform them on our products and services. Contact your agent/broker for specific information about their participation. The contract holder is not entitled to a return of any premium or other payment made to Cigna Healthcare company unless the Cigna Healthcare company agrees otherwise in writing. The Cigna Healthcare companies may use payments received for any purpose in its sole discretion. If the contract holder is a Public Entity located in California, you are asked to forward this report to the governing board. Part 1, line 2a, 2b, 3b and/or 3c: Represents the amount of Commissions/Benefit Advisor Fees paid during the contract year. This amount is reflective of payments made during the contract year that may be attributable to multiple contract years. Part 1, line 3b and/or c: May include prior year Commissions/Benefit Advisor Fees not previously reported. Part 1, line 3b and/or c: There may be adjustments made to Commissions and/or Benefit Advisor Fee payments outside the policy period that are not reflected on this form. Line 10a: May reflect amounts paid for surcharges on provider charges or other assessments imposed under applicable state law. Line 10a: Includes payments by State Continuant of \$0 administered by Cigna Healthcare and applicable to your account. • If applicable and provided with this reporting, the Appendix to Schedule A entities' allocation is based on averaged premium, Commissions/Benefit Advisor Fees and available lives. • If applicable and provided with this reporting, the Appendix to Schedule A entities' allocation for broker/general agent Commission/Benefit Advisor Fee amounts do not include Platinum/Supplemental bonus payments as they are paid lump sum to brokers/general agents and are included on the Schedule A summary page reporting. • If applicable and provided with this reporting, the Appendix to Schedule A entities' reports the number of employees covered rather than employees and dependents. Subscriber and membership information is available for your contract policy year on the employer portal at www.cignaaccess.com, report titled, Subscriber and Membership Reporting. • The premium reported does not reflect the rebates, if any, under the Patient Protection and Affordable Care Act that may have been paid for any prior plan year. • Premium also includes taxes, fees and assessments imposed under the Patient Protection and Affordable Care Act.					



Schedule A Insurance Information					
Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator					
A. Plan Name		CH EMPLOYMENT SERVICES, LLC		B. Three-Digit Plan #(PN)	
C. Plan Sponsor's Name:		Plan will Provide		D. Company Identification Number:	
Plan will Provide		Plan will Provide		Plan will Provide	
Part I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)					
1. Coverage Information (a) Name of Insurance Carrier: Cigna Health and Life Insurance Company and affiliates ("Cigna")					
(b) EIN	(c) NAIC Code	(d) Contract or Identification Number	(e) Approx.no.of persons covered at end of policy or contract year	Policy/Contract Year (f) From (g) To	
59-1031071	67369	3340783	207 Employees	03/01/2025	02/28/2026
2. Insurance fees and commissions information. Enter total fees and commissions paid					
(a) Total Amount of commissions paid			(b) Total Amount of fees paid		
\$12,826			\$0		
3. Persons receiving commissions and fees.		Fees and commissions paid			
(a) Name and address of the agent, broker or other person to who commissions and fees were paid	(b) Amount of sales and base commissions paid	(c) Amount*	(d) Purpose*	(e) Organization code	
Non Experience - Rated		*Refer to footnotes for incentive \$\$ amounts and purpose as applicable			
ALL ATLANTIC BENEFITS LLC, 200 S PARK RD, STE 475, HOLLYWOOD, FL, 33021	\$12,826	\$0		3- Insurance Agent or Broker	
Part II Investment and Annuity Contract Information					
Outstanding Monies Due >			This section not applicable to this Plan		
\$0			contract number of identification > same as 1d		
Part III Welfare Benefit Contract Information					
If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where 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 information	(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 Unemploy	(h) ☐ Prescription drug	
	(i) ☐ Stop Loss (Large deductible)	(j) ☒ HMO contract	(k) ☐ PPO Contract	(l) ☒ Indemnity contract	
	(m) ☒ Other (Prepaid Dental)				
9. Experience-Rated Contracts This section not applicable for this Plan					
10. Nonexperience-rated contracts	(a) Total premiums or subscriptions charges paid to carrier				\$129,595
	Premium Due as of				06/22/2026
	(b) If the carrier, service or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount				\$0
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. > Answer "Not Applicable"					
Comments: ESTIMATED					
THE INFORMATION REFLECTED IN THIS REPORT IS ACCURATE AND COMPLETE BASED UPON INFORMATION AVAILABLE TO CIGNA HEALTHCARE COMPANIES AT THE TIME THIS REPORT IS PREPARED AND IS CERTIFIED AS BEING COMPLETE AND ACCURATE.					
NOTE TO POLICYHOLDERS: You may have responsibilities under law to determine whether the information contained in this report could be used to identify individuals either when combined with other information that you have or in any other manner and, if so, to take appropriate protective steps.					

Schedule A Insurance Information - Footnotes
Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator

A. Plan Name		CH EMPLOYMENT SERVICES, LLC		B. Three-Digit Plan #(PN)		Plan will Provide	
C. Plan Sponsor's Name:		Plan will Provide		D. Company Identification Number:		Plan will Provide	
Part I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)							
1. Coverage Information		(a) Name of Insurance Carrier:Cigna Health and Life Insurance Company and affiliates ("Cigna")					
(b) EIN 59-1031071	(c) NAIC Code 67369	(d) Contract or Identification Number 3340783	(e) Approx.no.of persons covered at end of policy or contract year 207 Employees		(f) From (g) To 03/01/2025 - 02/28/2026		

Part I, line 1a: "Name of Insurance Carrier", (b) "EIN", (c) "NAIC Code" - The plan to which this report applies may be funded by contracts issued by more than one Cigna Healthcare company each of which is an "insurance carrier." The issuance of multiple insurance carrier contracts is necessary to cover individuals who participate in the same plan but reside in different geographic locations. As the Cigna Healthcare companies whose contracts fund the plan are grouped as a single unit by Cigna Healthcare for purposes of underwriting the plan, combining the information with respect to these individual contracts in this report will provide more meaningful insurance information for the Schedule A. The individual contracts of the Cigna Healthcare companies are grouped as a unit for purposes of this report. To reference individual contracts please refer to the Schedule A Appendix pages contained within this reporting package, if applicable.

Part I, line 2a, 2b: The following amounts were paid to your broker(s) / consultant(s) during the contract year:

Commissions: **\$12,826** General Agent Fees: **\$0** Benefit Advisor Fees: **\$0**

Part I, line 3c: Incentive compensation payments based upon persons/members in your plan and/or lump sum amount: **\$0** (Broker and General Agents combined) attributable to your plan for the 2025 calendar year. These amounts are funded from Cigna companies general overhead. Contact your broker/consultant for further details.

In addition to the Commissions/Benefit Advisor Fees reported, Cigna Healthcare enters into compensation programs under which certain agents and brokers provide our companies with market intelligence produce and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific policies, is funded from our general overhead, and is not required to be reported on Schedule A. Your agent or broker may also have participated at our expense, in events we sponsor to inform them on our products and services. Contact your agent/broker for specific information about their participation.

The contract holder is not entitled to a return of any premium or other payment made to Cigna Healthcare company unless the Cigna Healthcare company agrees otherwise in writing. The Cigna Healthcare companies may use payments received for any purpose in its sole discretion.

If the contract holder is a Public Entity located in California, you are asked to forward this report to the governing board.

Part I, line 2a, 2b, 3b and/or 3c: Represents the amount of Commissions/Benefit Advisor Fees paid during the contract year. This amount is reflective of payments made during the contract year that may be attributable to multiple contract years.

Part I, line 3b and/or c: May include prior year Commissions/Benefit Advisor Fees not previously reported.

Part I, line 3b and/or c: There may be adjustments made to Commissions and/or Benefit Advisor Fee payments outside the policy period that are not reflected on this form.

Line 10a: May reflect amounts paid for surcharges on provider charges or other assessments imposed under applicable state law.

Line 10a: Includes payments by State Continuant of \$0 administered by Cigna Healthcare and applicable to your account.

- If applicable and provided with this reporting, the Appendix to Schedule A entities' allocation is based on averaged premium, Commissions/Benefit Advisor Fees and available lives.
- If applicable and provided with this reporting, the Appendix to Schedule A entities' allocation for broker/general agent Commission/Benefit Advisor Fee amounts do not include Platinum/Supplemental bonus payments as they are paid lump sum to brokers/general agents and are included on the Schedule A summary page reporting.
- If applicable and provided with this reporting, the Appendix to Schedule A entities' reports the number of employees covered rather than employees and dependents. Subscriber and membership information is available for your contract policy year on the employer portal at www.cignaaccess.com, report titled, Subscriber and Membership Reporting.
- The premium reported does not reflect the rebates, if any, under the Patient Protection and Affordable Care Act that may have been paid for any prior plan year.
- Premium also includes taxes, fees and assessments imposed under the Patient Protection and Affordable Care Act.

Cigna Health and Life Insurance Company

900 Cottage Grove Road

Hartford, CT 06152

**Schedule A Insurance Information - Appendix to 1a, b and c****Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator****Plan Name :** CH EMPLOYMENT SERVICES, LLC**Contract or Identification Number:** 3340783**Policy /Contract Year :** 03/01/2025 – 02/28/2026

The below information is to further detail the non-experience rated premium for 5500 reporting based on applicable Dental NAIC code:

Company Information		5500 Section	5500 line item	DHMO Plan
Name : EIN Code : NAIC Code :	Cigna Dental Health of California, Inc. 59-2600475 N/A	Part I	line 1e	15 average employees
			line 2a	\$229
			line 2b	\$0
			line 3a	ALL ATLANTIC BENEFITS LLC, 200 S PARK RD, STE 475, HOLLYWOOD, FL, 33021
			line 3b	\$229
			line 3c	\$0
		Part III	line 10a	\$2,292

Cigna Health and Life Insurance Company

900 Cottage Grove Road

Hartford, CT 06152

**Schedule A Insurance Information - Appendix to 1a, b and c****Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator****Plan Name :** CH EMPLOYMENT SERVICES, LLC**Contract or Identification Number:** 3340783**Policy /Contract Year :** 03/01/2025 – 02/28/2026

The below information is to further detail the non-experience rated premium for 5500 reporting based on applicable Dental NAIC code:

Company Information		5500 Section	5500 line item	DHMO Plan
Name : EIN Code : NAIC Code :	Cigna Dental Health of Florida, Inc. 59-1611217 52021	Part I	line 1e	25 average employees
			line 2a	\$385
			line 2b	\$0
			line 3a	ALL ATLANTIC BENEFITS LLC, 200 S PARK RD, STE 475, HOLLYWOOD, FL, 33021
			line 3b	\$385
			line 3c	\$0
		Part III	line 10a	\$3,847

Cigna Health and Life Insurance Company

900 Cottage Grove Road

Hartford, CT 06152

**Schedule A Insurance Information - Appendix to 1a, b and c****Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator****Plan Name :** CH EMPLOYMENT SERVICES, LLC**Contract or Identification Number:** 3340783**Policy /Contract Year :** 03/01/2025 – 02/28/2026

The below information is to further detail the non-experience rated premium for 5500 reporting based on applicable Dental NAIC code:

Company Information		5500 Section	5500 line item	DHMO Plan
Name : EIN Code : NAIC Code :	Cigna Dental Health of Kentucky, Inc. 59-2619589 52108	Part I	line 1e	8 average employees
			line 2a	\$128
			line 2b	\$0
			line 3a	ALL ATLANTIC BENEFITS LLC, 200 S PARK RD, STE 475, HOLLYWOOD, FL, 33021
			line 3b	\$128
			line 3c	\$0
		Part III	line 10a	\$1,282



Schedule A Insurance Information					
Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator					
A. Plan Name		CH EMPLOYMENT SERVICES, LLC		B. Three-Digit Plan #(PN)	
C. Plan Sponsor's Name:		Plan will Provide		D. Company Identification Number:	
Plan will Provide					
Part I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)					
1. Coverage Information (a) Name of Insurance Carrier: Cigna Health and Life Insurance Company and affiliates ("Cigna")					
(b) EIN	(c) NAIC Code	(d) Contract or Identification Number	(e) Approx. no. of persons covered at end of policy or contract year	Policy/Contract Year (f) From (g) To	
59-1031071	67369	3340783	176 Employees	03/01/2025	02/28/2026
2. Insurance fees and commissions information. Enter total fees and commissions paid					
(a) Total Amount of commissions paid			(b) Total Amount of fees paid		
\$2,331			\$0		
3. Persons receiving commissions and fees.		Fees and commissions paid			
(a) Name and address of the agent, broker or other person to who commissions and fees were paid	(b) Amount of sales and base commissions paid	(c) Amount*	(d) Purpose*	(e) Organization code	
Non Experience - Rated		*Refer to footnotes for incentive \$\$ amounts and purpose as applicable			
ALL ATLANTIC BENEFITS LLC, 200 S PARK RD, STE 475, HOLLYWOOD, FL, 33021	\$2,331	\$0		3- Insurance Agent or Broker	
Part II Investment and Annuity Contract Information					
Outstanding Monies Due >			This section not applicable to this Plan		
\$0			contract number of identification > same as 1d		
Part III Welfare Benefit Contract Information					
If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where 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 information	(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 Unemploy	(h) ☐ Prescription drug	
	(i) ☐ Stop Loss (Large deductible)	(j) ☐ HMO contract	(k) ☐ PPO Contract	(l) ☒ Indemnity contract	
	(m) ☐ Other (Prepaid Dental)				
9. Experience-Rated Contracts This section not applicable for this Plan					
10. Nonexperience-rated contracts	(a) Total premiums or subscriptions charges paid to carrier				\$23,307
	Premium Due as of 06/22/2026				\$0
	(b) If the carrier, service or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount				
Specify nature of costs					
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. >			Answer "Not Applicable"		

Comments: ESTIMATED

THE INFORMATION REFLECTED IN THIS REPORT IS ACCURATE AND COMPLETE BASED UPON INFORMATION AVAILABLE TO CIGNA HEALTHCARE COMPANIES AT THE TIME THIS REPORT IS PREPARED AND IS CERTIFIED AS BEING COMPLETE AND ACCURATE.

NOTE TO POLICYHOLDERS: You may have responsibilities under law to determine whether the information contained in this report could be used to identify individuals either when combined with other information that you have or in any other manner and, if so, to take appropriate protective steps.



Schedule A Insurance Information - Footnotes Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator				
A. Plan Name		CH EMPLOYMENT SERVICES, LLC		B. Three-Digit Plan #(PN)
C. Plan Sponsor's Name:		Plan will Provide		D. Company Identification Number:
Plan will Provide				
Part I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)				
1. Coverage Information (a) Name of Insurance Carrier: Cigna Health and Life Insurance Company and affiliates ("Cigna")				
(b) EIN 59-1031071	(c) NAIC Code 67369	(d) Contract or Identification Number 3340783	(e) Approx.no.of persons covered at end of policy or contract year 176 Employees	Policy/Contract Year (f) From 03/01/2025 (g) To 02/28/2026
Part I, line 1a: "Name of Insurance Carrier", (b) "EIN", (c) "NAIC Code" - The plan to which this report applies may be funded by contracts issued by more than one Cigna Healthcare company each of which is an "insurance carrier." The issuance of multiple insurance carrier contracts is necessary to cover individuals who participate in the same plan but reside in different geographic locations. As the Cigna Healthcare companies whose contracts fund the plan are grouped as a single unit by Cigna Healthcare for purposes of underwriting the plan, combining the information with respect to these individual contracts in this report will provide more meaningful insurance information for the Schedule A. The individual contracts of the Cigna Healthcare companies are grouped as a unit for purposes of this report. To reference individual contracts please refer to the Schedule A Appendix pages contained within this reporting package, if applicable. Part I, line 2a, 2b: The following amounts were paid to your broker(s) / consultant(s) during the contract year: Commissions: \$2,331 General Agent Fees: \$0 Benefit Advisor Fees: \$0 Part I, line 3c: Incentive compensation payments based upon persons/members in your plan and/or lump sum amount: \$0 (Broker and General Agents combined) attributable to your plan for the 2025 calendar year. These amounts are funded from Cigna companies general overhead. Contact your broker/consultant for further details. In addition to the Commissions/Benefit Advisor Fees reported, Cigna Healthcare enters into compensation programs under which certain agents and brokers provide our companies with market intelligence produce and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific policies, is funded from our general overhead, and is not required to be reported on Schedule A. Your agent or broker may also have participated at our expense, in events we sponsor to inform them on our products and services. Contact your agent/broker for specific information about their participation. The contract holder is not entitled to a return of any premium or other payment made to Cigna Healthcare company unless the Cigna Healthcare company agrees otherwise in writing. The Cigna Healthcare companies may use payments received for any purpose in its sole discretion. If the contract holder is a Public Entity located in California, you are asked to forward this report to the governing board. Part 1, line 2a, 2b, 3b and/or 3c: Represents the amount of Commissions/Benefit Advisor Fees paid during the contract year. This amount is reflective of payments made during the contract year that may be attributable to multiple contract years. Part 1, line 3b and/or c: May include prior year Commissions/Benefit Advisor Fees not previously reported. Part 1, line 3b and/or c: There may be adjustments made to Commissions and/or Benefit Advisor Fee payments outside the policy period that are not reflected on this form. Line 10a: May reflect amounts paid for surcharges on provider charges or other assessments imposed under applicable state law. Line 10a: Includes payments by State Continuant of \$0 administered by Cigna Healthcare and applicable to your account. • If applicable and provided with this reporting, the Appendix to Schedule A entities' allocation is based on averaged premium, Commissions/Benefit Advisor Fees and available lives. • If applicable and provided with this reporting, the Appendix to Schedule A entities' allocation for broker/general agent Commission/Benefit Advisor Fee amounts do not include Platinum/Supplemental bonus payments as they are paid lump sum to brokers/general agents and are included on the Schedule A summary page reporting. • If applicable and provided with this reporting, the Appendix to Schedule A entities' reports the number of employees covered rather than employees and dependents. Subscriber and membership information is available for your contract policy year on the employer portal at www.cignaaccess.com, report titled, Subscriber and Membership Reporting. • The premium reported does not reflect the rebates, if any, under the Patient Protection and Affordable Care Act that may have been paid for any prior plan year. • Premium also includes taxes, fees and assessments imposed under the Patient Protection and Affordable Care Act.				



Dear Valued Customer,

Attached please find the following financial information for your employee benefit plan insured and/or administered by Cigna Health and Life Insurance Company, a Cigna Healthcare company.

- **Annual Reconciliation Disclosure**

Cigna Healthcare provides an Annual Reconciliation Disclosure under direct issue for Non-ERISA clients to support policy year reporting of premiums/fees received, commissions paid, reserve balances and margin/deficit outcomes, where applicable.

- Information for your use in preparing **ERISA Form 5500 Schedule A* and/or Schedule C**

***Schedule A Insurance Information:**

Please note that insurance information is reported and certified on a contract year basis only. Where the plan year is different than the contract year, Schedule A instructions require that the insurance information be reported for "the insurance contract year ending within the plan year." Insurance information requested on a plan year rather than contract year basis will not be certified.

Consistent with Schedule A instructions, the Insurance Information is reported on a contract basis and insurance information for multiple contracts may be combined if experience rates as a unit. Request for information on any other basis will not be certified.

Compensation for Service and/or General Agent Agreements is reflected in the report but may not have been directly paid to the producer by the Plan. Please note that while these additional payments are associated with your plan for reporting purposes, the related expenses may not impact your specific case level rates and premium.

If your plan's funding type has changed, the items shown correspond to the original funding type prior to conversion.

For cancelled plans or conversions, you must notify Cigna Healthcare in writing within 30 days of receipt if you dispute any of the information in the enclosed report. Failure to do so will indicate your agreement with any information not disputed.

If you have any questions, please contact your Cigna Sales representative. For assistance with preparing the Form 5500, consult your tax or legal advisor.

**SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I**

**CH EMPLOYMENT SERVICES LLC
MIAMI, FL**

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
 EIN Number: 47-0322111
 Group Identification Number: G000AW5T
 Legacy Group ID: GLUG0AW5T
 Type of Contract: NON-RETENTION

Data for Period: 03-01-2025 to 03-01-2026

Benefits Provided	Persons Covered
Life & AD&D	273

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
CENTRO BENEFITS GROUP, LLC 325 N KIRKWOOD RD STE 300 KIRKWOOD, MO 63122	0	1,404	Other Compensation	3
ALL ATLANTIC BENEFITS LLC 200 S PARK RD STE 475 HOLLYWOOD, FL 33021	4,213		Agent or Broker of Record	3
ALL ATLANTIC BENEFITS LLC 200 S PARK RD STE 475 HOLLYWOOD, FL 33021	0	1,468	Other Compensation	3
UNITED BENEFIT ADVISORS OF FLORIDA, 6885 BELFORT OAKS PL STE 210 JACKSONVILLE, FL 32216	3,259		Agent or Broker of Record	3
	<u>1,472</u>	<u>2,872</u>		

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 49,812

Memo Items: Benefit Charges - Claims Paid 0
 Administrative Service Fees 0

Group Office: SOUTH FLORIDA

0-0
58803647-1
00002775

COLOR702E 1256 5009 125 36 20260410 PG 2 OF 3

**SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I**

**CH EMPLOYMENT SERVICES LLC
MIAMI, FL**

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
 EIN Number: 47-0322111
 Group Identification Number: G000AW5T
 Legacy Group ID: GLTD0AW5T
 Type of Contract: NON-RETENTION
 Data for Period: 03-01-2025 to 03-01-2026

Benefits Provided **Persons Covered**
 Long Term Disability Insured 273

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
CENTRO BENEFITS GROUP, LLC 325 N KIRKWOOD RD STE 300 KIRKWOOD, MO 63122	0	1,672	Other Compensation	3
ALL ATLANTIC BENEFITS LLC 200 S PARK RD STE 475 HOLLYWOOD, FL 33021	0	1,766	Other Compensation	3
ALL ATLANTIC BENEFITS LLC 200 S PARK RD STE 475 HOLLYWOOD, FL 33021	5,015		Agent or Broker of Record	3
UNITED BENEFIT ADVISORS OF FLORIDA, 6885 BELFORT OAKS PL STE 210 JACKSONVILLE, FL 32216	3,849		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 59,092

Memo Items: Benefit Charges – Claims Paid 0
 Administrative Service Fees 0

Group Office: SOUTH FLORIDA



**SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I**

**CH EMPLOYMENT SERVICES LLC
MIAMI, FL**

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
 EIN Number: 47-0322111
 Group Identification Number: G000AW5T
 Legacy Group ID: GVTLOAW5T
 Type of Contract: NON-RETENTION

Data for Period: 03-01-2025 to 03-01-2026

Benefits Provided **Persons Covered**
 Term Life - Voluntary 54

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
CENTRO BENEFITS GROUP, LLC 325 N KIRKWOOD RD STE 300 KIRKWOOD, MO 63122	0	871	Other Compensation	3
ALL ATLANTIC BENEFITS LLC 200 S PARK RD STE 475 HOLLYWOOD, FL 33021	0	894	Other Compensation	3
ALL ATLANTIC BENEFITS LLC 200 S PARK RD STE 475 HOLLYWOOD, FL 33021	2,612		Agent or Broker of Record	3
UNITED BENEFIT ADVISORS OF FLORIDA, 6885 BELFORT OAKS PL STE 210 JACKSONVILLE, FL 32216	1,902 <u>4,514</u>	1,765 <u>02,958</u>	Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 30,098

Memo Items: Benefit Charges - Claims Paid 0
 Administrative Service Fees 0

Group Office: SOUTH FLORIDA

**SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I**

**CH EMPLOYMENT SERVICES LLC
MIAMI, FL**

Name of Carrier: United of Omaha Life Insurance Company -- NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000AW5T **Data for Period:** 03-01-2025 to 03-01-2026
Legacy Group ID: GUC 0AW5T
Type of Contract: NON-RETENTION

Benefits Provided **Persons Covered**
ShortTerm Disability Voluntary 144

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
CENTRO BENEFITS GROUP, LLC 325 N KIRKWOOD RD STE 300 KIRKWOOD, MO 63122	0	754	Other Compensation	3
ALL ATLANTIC BENEFITS LLC 200 S PARK RD STE 475 HOLLYWOOD, FL 33021	0	776	Other Compensation	3
ALL ATLANTIC BENEFITS LLC 200 S PARK RD STE 475 HOLLYWOOD, FL 33021	2,261		Agent or Broker of Record	3
UNITED BENEFIT ADVISORS OF FLORIDA, 6885 BELFORT OAKS PL STE 210 JACKSONVILLE, FL 32216	1,669		Agent or Broker of Record	3
	3,930	1,530		

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 26,199

Memo Items: Benefit Charges – Claims Paid 0
Administrative Service Fees 0

Group Office: SOUTH FLORIDA





3300 Mutual of Omaha Plaza | Omaha, NE 68175

April 10, 2026



CH EMPLOYMENT SERVICES LLC
2200 BISCAYNE BLVD
MIAMI, FL 33137

000002775
M202

Re: Certified Information for Department of Labor
Form 5500, Schedule A – Group Number(s):
GLTD0AW5T GLUG0AW5T
GVTL0AW5T

GUC 0AW5T

Thank you for choosing Mutual of Omaha as your group insurance carrier. We appreciate the opportunity to service you and your employees. Attached, you'll find the Form 5500, Schedule A.

I certify that the attached information for the Form 5500, Schedule A, Part I and Part III, has been taken from our company records and is correct to the best of my knowledge. Mutual of Omaha is providing you with the attached information but makes no representation regarding reporting requirements. Please consult your attorney or other advisor as to your reporting obligations.

For questions, please contact your dedicated Customer Service team or call 1-800-655-5142.

Sincerely,

Nancy A. Sinnett
Vice President
Finance Operations



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



AT 001 000088 UNLTA9K1 000000



C H EMPLOYMENT SERVICES LLC
ATTN: EDGARDO VEGA
2200 BISCAYNE BLVD
MIAMI FL 33137-5283

April 9, 2026

Re: Information Schedule A (Form 5500)
BCN: E4405189

Dear Edgardo Vega:

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: C H Employment Services Llc

Billing Control Number: E4405189

Plan Year Date Range: 03/01/2025 - 02/28/2026

Organization Code For Agents/Producers: 3

Amount for Pre-tax or Employer Paid Premium: \$117,354.50

Amount for After Tax Paid Premium: \$66,972.46

Total Paid Premium: \$184,326.96

APPROXIMATE NUMBER OF PERSONS COVERED IN FEBRUARY 2026: 175

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
Michael Alan Schooley 11107 Sw 138th Pl Miami FL 33186	\$254.97	\$0.00	\$254.97	\$33.82
Andrea Browning 145 19th Ave Se St Petersburg FL 33705	\$1,781.71	\$1,076.74	\$2,858.45	\$868.01
Guy Sanmiguel 4965 Sw 134th Ave Miramar FL 33027	\$328.88	\$779.42	\$1,108.30	\$36.02
Adam Ira Brown 700 Ne 7th Ave Apt 6 Fort Lauderdale FL 33304	\$612.21	\$850.15	\$1,462.36	\$339.39



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
Group Supplemental Benefits Inc 39970 Stacy Ct Murrieta CA 92563	\$20.79	\$8.03	\$28.82	\$24.85
R & B Enrollment Services Inc Po Box 3216 Crestline CA 92325	\$4.56	\$0.00	\$4.56	\$0.00
Value Added Solutions 1161 Heritage Ct Sun Prairie WI 53590	\$33.35	\$41.19	\$74.54	\$259.70
Michael Marshall 1134 Se 6th Ct Dania Beach FL 33004	\$0.21	\$0.00	\$0.21	\$0.34
Florida Group Benefits Inc 8421 Sw 124th Ave Apt 103 Miami FL 33183	\$479.53	\$127.32	\$606.85	\$89.17
Erick Tavaraz 212 Springview Dr Marshall WI 53559	\$33.35	\$41.19	\$74.54	\$95.40
Yesenia A Hernandez 6715 S Keeler Ave Chicago IL 60629	\$485.37	\$592.25	\$1,077.62	\$323.09
World Insurance Associates Llc 100 Wood Ave South Iselin NJ 08830	\$4,606.42	\$3,289.03	\$7,895.45	\$138.37
Brito Benefits Solutions Inc 14716 Sw 112th Ter Miami FL 33196	\$1,062.44	\$532.82	\$1,595.26	\$184.38
Dana Marie Mowatt 23701 S Western Ave Spc 112 Torrance CA 90501	\$80.63	\$25.47	\$106.10	\$11.92
Wendy Sue Gershow 3217 Star Ave Oakland CA 94619	\$283.25	\$201.30	\$484.55	\$60.72
Maria C Gonzalez 11677 Sandpiper Ct Moreno Valley CA 92557	\$35.97	\$25.96	\$61.93	\$0.00
Susan Gold Stokes 104 Misty Hollow Way Huntsville AL 35806	\$0.00	\$3.74	\$3.74	\$0.00

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 Guillory 5116 Furlong Way Antioch CA 94531	\$18.92	\$11.93	\$30.85	\$6.46
Jon Curtis Richert 35925 Leah Ln Yucaipa CA 92399	\$20.79	\$8.03	\$28.82	\$12.69
Laura Runyeon 981 Quarry Street Petaluma CA 94954	\$18.04	\$11.44	\$29.48	\$7.12
Rose Villalon Pasquel 552 E Carson St # 104-412 Carson CA 90745	\$491.72	\$163.50	\$655.22	\$15.72
Deborah Lynn Wells 5809 Mark Twain Ave Sacramento CA 95820	\$93.37	\$448.67	\$542.04	\$15.53
Luc Joseph 548 Nw 51st St Miami FL 33127	\$11.44	\$0.00	\$11.44	\$0.00
Erlande Michel 3141 La France Ave Sw Palm Bay FL 32908	\$19.57	\$7.15	\$26.72	\$0.00
Michel Gutierrez 4703 W Mcelroy Avenue Apt 19 Tampa FL 33611	\$104.72	\$0.00	\$104.72	\$2.51
Jennifer Groot 931 W Marshall Blvd San Bernardino CA 92405	\$13.07	\$0.00	\$13.07	\$0.00
Jcastellanos And Associates Inc 7441 Figura Drive Justice IL 60458	\$15.84	\$5.94	\$21.78	\$0.00
Benefitlab Inc 9647 Sugar Pines Ct Davie FL 33328	\$0.21	\$0.00	\$0.21	\$0.06
All Atlantic Benefits Llc 3440 Holly Blvd Hollywood FL 33021	\$7,442.24	\$5,699.50	\$13,141.74	\$0.00
Modern Life Financial Group 2826 Sw 145th Ct Miami FL 33175	\$92.29	\$0.00	\$92.29	\$6.09



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
Single Point Enrollment Solutions I 12002 Sw 128th Ct Ste 201 Miami FL 33186	\$5,653.89	\$2,670.81	\$8,324.70	\$4,561.87
World Prime Solutions 7000 Nova Dr Apt 203 Davie FL 33317	\$209.33	\$154.99	\$364.32	\$49.27
Grand Totals	\$24,309.08	\$16,776.57	\$41,085.65	\$7,142.50

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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The Paul Revere Life Insurance Company
P O Box 1365
Columbia, S 29202-32

 Colonial Voluntary Benefits_{SM}



AT 001 000089 UNLTA9K1 000000



C H EMPLOYMENT SERVICES LLC
ATTN: EDGARDO VEGA
2200 BISCAYNE BLVD
MIAMI FL 33137-5283

April 9, 2026

Re: Information Schedule A (Form 5500)
BCN: E4405189

Dear Edgardo Vega:

The Paul Revere Life Insurance Company is pleased to certify the enclosed Schedule A information on your Paul Revere 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. Paul Revere 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.

Paul Revere'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: The Paul Revere Life Insurance Company
P O Box 1365
Columbia, S 29202-32

Carrier EIN: 04-1590994
Carrier NAIC Code: 67598

Account Name: C H Employment Services Llc
Billing Control Number: E4405189
Plan Year Date Range: 03/01/2025 - 02/28/2026

Organization Code For Agents/Producers: 3

Amount for Pre-tax or Employer Paid Premium: \$2,832.92
Amount for After Tax Paid Premium: \$948.37
Total Paid Premium: \$3,781.29

APPROXIMATE NUMBER OF PERSONS COVERED IN FEBRUARY 2026: 4

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
Michael Alan Schooley 11107 Sw 138th Pl Miami FL 33186	\$30.10	\$0.00	\$30.10	\$1.52
Andrea Browning 145 19th Ave Se St Petersburg FL 33705	\$44.95	\$24.11	\$69.06	\$0.00
Adam Ira Brown 700 Ne 7th Ave Apt 6 Fort Lauderdale FL 33304	\$28.27	\$83.54	\$111.81	\$18.78
World Insurance Associates Llc 100 Wood Ave South Iselin NJ 08830	\$48.53	\$95.67	\$144.20	\$0.00



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
Brito Benefits Solutions Inc 14716 Sw 112th Ter Miami FL 33196	\$29.05	\$15.71	\$44.76	\$2.95
All Atlantic Benefits Llc 3440 Holly Blvd Hollywood FL 33021	\$77.87	\$146.13	\$224.00	\$0.00
Single Point Enrollment Solutions I 12002 Sw 128th Ct Ste 201 Miami FL 33186	\$105.99	\$74.69	\$180.68	\$25.98
Grand Totals	\$364.76	\$439.85	\$804.61	\$49.23

Certification Statement

The Paul Revere Life 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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