

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 2024 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2024 or fiscal plan year beginning 12/01/2024 and ending 11/30/2025	
A	This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) ☐ a single-employer plan ☒ a DFE (specify) <u>G</u> ☐ 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	1b Three-digit plan number (PN) ▶ 501
	ASSOCIATION HEALTH AND WELFARE VEBA MASTER TRUST	1c Effective date of plan 01/01/2014
2a	Plan sponsor's name (employer, if for a single-employer plan)	2b Employer Identification Number (EIN) 46-7130790
	Mailing address (include room, apt., suite no. and street, or P.O. Box)	2c Plan Sponsor's telephone number 502-499-6880
	City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)	2d Business code (see instructions)
	SHEPHERD INSURANCE	
9600 BROWNSBORO ROAD SUITE 300 LOUISVILLE, KY 40241		

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.	08/25/2026	STEPHEN GREGORY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Filed with authorized/valid electronic signature.	08/25/2026	STEPHEN GREGORY
	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	5 697
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) 695 6a(2) 471 6b 1 6c 0 6d 472 6e 6f 6g(1) 6g(2) 6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7

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

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

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

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 4
- (4)** ☒ **C** (Service Provider Information)
- (5)** ☒ **D** (DFE/Participating Plan Information)
- (6)** ☐ **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 12/01/2024 and ending 11/30/2025		
A Name of plan	B Three-digit plan number (PN)	501
ASSOCIATION HEALTH AND WELFARE VEBA MASTER TRUST		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
SHEPHERD INSURANCE	46-7130790	

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

ANTHEM INSURANCE COMPANIES, 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
35-0781558	28207	1007143	880	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
156339	44

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

SHEPHERD INSURANCE LLC 111 CONGRESSIONAL BLVD STE 100 CARMEL, IN 46032

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
89991			3

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

ABC BENEFITS GROUP LLC 5001 SHADELAND AVE INDIANAPOLIS, IN 46226

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
43113			3

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

KEYSTONE INSURANCE & BENEFITS GROUP

13800 JACKSON ROAD
MISHAWAKA, IN 46544

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
6447			3

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

THE HILB GROUP OF NEW ENGLAND LLC

2000 CHAPEL VIEW BLVD
CRANSTON, RI 02920

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3213			3

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

ONI RISK PARTNERS INC

PO BOX 80159
INDIANAPOLIS, IN 46280

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2604	44		3

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

SYCAMORE INC ASSOC LLC

999 OHIO STREET
TERRE HAUTE, IN 47807

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2289			3

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

WHARTON INSURANCE & FINANCIAL SERV

12735 MEETING HOUSE ROAD SUITE 100
CARMEL, IN 46032

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1806			3

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

CIC 2 INC

8395 KEYSTONE CROSSING 315
INDIANAPOLIS, IN 46240

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1512			3

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

FINNEY, MAUREEN

100 OLD WILSON BRIDGE RD, STE 214
WORTHINGTON, OH 43085

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1337			3

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

CREATIVE BENEFIT SOLUTIONS LLC

205 N LAKE STREET
WARSAW, IN 46580

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
756			3

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

BSC AGENCY LLC

1025 ASHWORTH RD STE 101
WEST DES MOINES, IA 50265

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
693			3

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

RL JONES INSURANCE GROUP LLC

20236 HAGUE RD
NOBLESVILLE, IN 46062

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
660			3

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

MCNEELY, STEPHEN

205 MARIANNA DRIVE
AUBURNDALE, FL 33923

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
658			3

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

HUB INTERNATIONAL MIDWEST LIMITED

2120 PEWAUKEE RD. SUITE 202
WAUKESHA, WI 53188

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
651			3

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

GERMAN AMERICAN INSURANCE INC

PO BOX 1008
JASPER, IN 47547

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
504			3

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

STEWART BRIMNER PETERS & DONAVAN IN

3702 RUPP DRIVE
FORT WAYNE, IN 46815

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
105			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	

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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☒ Health (other than dental or vision)
b ☐ Dental
c ☐ Vision
d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ 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	6602976
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 12/01/2024 and ending 11/30/2025	
A Name of plan ASSOCIATION HEALTH AND WELFARE VEBA MASTER TRUST	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 SHEPHERD INSURANCE	D Employer Identification Number (EIN) 46-7130790

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

(a) Name of insurance carrier
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0236788	497	01/01/2025	12/31/2025

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

(a) Total amount of commissions paid 36412	(b) Total amount of fees paid 8997
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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
SHEPHERD INSURANCE LLC 9600 BROWNSBORO RD STE 300
LOUISVILLE, KY 40241-3904

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
25129		BASE COMMISSIONS	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
EMERSON ROGERS LLC 1787 SENTRY PKWY W BLDG 16 STE 320
BLUE BELL, PA 19422-2239

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
11283		BASE COMMISSIONS	3

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

CAPSTONE BENEFIT GROUP INC

1025 ASHWORTH ROAD STE 1
WEST DES MOINES, IA 50265-3542

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	6761	TPA ADMIN FEES	5

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

EMERSON ROGERS LLC

1787 SENTRY PKWY W BLDG 16 STE 320
BLUE BELL, PA 19422-2239

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	2236	SUPPLEMENTAL COMPENSATION	3

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

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

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

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

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

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

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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	194038
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 12/01/2024 and ending 11/30/2025		
A Name of plan	B Three-digit plan number (PN)	501
ASSOCIATION HEALTH AND WELFARE VEBA MASTER TRUST		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
SHEPHERD INSURANCE	46-7130790	

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

(a) Name of insurance carrier

METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0237994		01/01/2025	12/31/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
43	7

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

SHEPHERD INSURANCE LLC 9600 BROWNSBORO RD STE 300
LOUISVILLE, KY 40241-3904

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

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

EMERSON ROGERS LLC 1787 SENTRY PKWY W BLDG 16 STE 320
BLUE BELL, PA 19422-2239

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

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

CAPSTONE BENEFIT GROUP INC

6110 TECHNOLOGY CENTER DR. STE. 500
INDIANAPOLIS, IN 46278-6016

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	5	TPA ADMIN FEES	5

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

EMERSON ROGERS LLC

1787 SENTRY PKWY W BLDG 16 STE 320
BLUE BELL, PA 19422-2239

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

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

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

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

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

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

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

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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☒ Health (other than dental or vision)
b ☐ Dental
c ☐ Vision
d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ 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	-171
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 12/01/2024 and ending 11/30/2025		
A Name of plan	B Three-digit plan number (PN)	501
ASSOCIATION HEALTH AND WELFARE VEBA MASTER TRUST		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
SHEPHERD INSURANCE	46-7130790	

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

(a) Name of insurance carrier					
METROPOLITAN LIFE INSURANCE COMPANY					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0237995		01/01/2025	12/31/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
50	8

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	
SHEPHERD INSURANCE LLC	111 CONGRESSIONAL BLVD STE 100 CARMEL, IN 46032-6661

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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
EMERSON ROGERS LLC	1787 SENTRY PKWY W BLDG 16 STE 320 BLUE BELL, PA 19422-2239

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

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

CAPSTONE BENEFIT GROUP INC

6110 TECHNOLOGY CENTER DR. STE. 500
INDIANAPOLIS, IN 46278-6016

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	6	TPA ADMIN FEES	3

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

EMERSON ROGERS LLC

1787 SENTRY PKWY W BLDG 16 STE 320
BLUE BELL, PA 19422-2239

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

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

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

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

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

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

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

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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☒ Health (other than dental or vision)
b ☐ Dental
c ☐ Vision
d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ 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	-594
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 C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2024
		This Form is Open to Public Inspection.

For calendar plan year 2024 or fiscal plan year beginning 12/01/2024 and ending 11/30/2025		
A Name of plan ASSOCIATION HEALTH AND WELFARE VEBA MASTER TRUST	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 SHEPHERD INSURANCE	D Employer Identification Number (EIN) 46-7130790	

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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

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

BUSINESSSOLVER, INC./CAPSTONE

1025 ASHWORTH ROAD
WEST DES MOINES, IA 50265

35-2260019

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 14 15	NONE	97548	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ASSOCIATED BUILDERS AND CONTRACTORS

5001 N SHADELAND AVENUE
INDIANAPOLIS, IN 46226

23-7298705

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 49	NONE	14970	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

L.M. HENDERSON & COMPANY, LLP

450 E 96TH STREET STE 200
INDIANAPOLIS, IN 46240

20-5520612

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 10	NONE	14500	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

ASSOCIATION INSURANCE MARKETERS

11420 BLUEGRASS PKWY
LOUISVILLE, KY 40299

46-1605932

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 13	NONE	12726	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

INDIANA MANUFACTURERS ASSOCIATION

30 S MERIDIAN ST STE 880
INDIANAPOLIS, IN 46204

35-0410440

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	7338	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

STOCK YARDS BANK AND TRUST COMPANY

1040 E MAIN STREET
LOUISVILLE, KY 40206

61-0354170

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
21 50	NONE	6327	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

SHEPHERD INSURANCE

111 CONGRESSIONAL BLVD
CARMEL, IN 46032

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	NONE	5233	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

a Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	ASSOCIATION HEALTH AND WELFARE VEBA MASTER TR	
b	Name of plan sponsor	BUILDING & DEVELOPMENT ASSOC OF SOUTHERN INDI	c EIN-PN 35-1377507-501
a	Plan name	ASSOCIATION HEALTH AND WELFARE VEBA MASTER TR	
b	Name of plan sponsor	ASSOCIATED BUILDERS & CONTRACTORS, INC.	c EIN-PN 23-7298705-501
a	Plan name	ASSOCIATION HEALTH AND WELFARE VEBA MASTER TR	
b	Name of plan sponsor	INDIANA BUILDERS ASSOCIATION	c EIN-PN 35-0920058-501
a	Plan name	ASSOCIATION HEALTH AND WELFARE VEBA MASTER TR	
b	Name of plan sponsor	SOUTHWEST INDIANA BUILDERS ASSOCIATION	c EIN-PN 35-1117068-501
a	Plan name	ASSOCIATION HEALTH AND WELFARE VEBA MASTER TR	
b	Name of plan sponsor	INDIANA MANUFACTURERS ASSOCIATION	c EIN-PN 35-0140440-501
a	Plan name	ASSOCIATION HEALTH AND WELFARE VEBA MASTER TR	
b	Name of plan sponsor	ARCHITECTS OF INDIANA ASSOCIATION	c EIN-PN 35-1118574-501
a	Plan name	ASSOCIATION HEALTH AND WELFARE VEBA MASTER TR	
b	Name of plan sponsor	INDIANA CPA SOCIETY	c EIN-PN 35-0846169-501
a	Plan name	ASSOCIATION HEALTH AND WELFARE VEBA MASTER TR	
b	Name of plan sponsor	PROFFESIONAL INSURUANCE AGENTS OF INDIANA	c EIN-PN 61-0862228-501
a	Plan name		
b	Name of plan sponsor		c EIN-PN
a	Plan name		
b	Name of plan sponsor		c EIN-PN
a	Plan name		
b	Name of plan sponsor		c EIN-PN
a	Plan name		
b	Name of plan sponsor		c EIN-PN

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
	For calendar plan year 2024 or fiscal plan year beginning 12/01/2024 and ending 11/30/2025	
	A Name of plan ASSOCIATION HEALTH AND WELFARE VEBA MASTER TRUST	B Three-digit plan number (PN) 501
C Plan sponsor's name as shown on line 2a of Form 5500 SHEPHERD INSURANCE	D Employer Identification Number (EIN) 46-7130790	

Part I	Asset and Liability Statement		
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.			
Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	297439	351547
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	49352	6894
(2) Participant contributions.....	1b(2)	2685	2297
(3) Other	1b(3)	703	550
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other.....	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	350179	361288
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h	36196	25945
i Acquisition indebtedness	1i		
j Other liabilities	1j	45177	51821
k Total liabilities (add all amounts in lines 1g through 1j)	1k	81373	77766
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	268806	283522

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	8850	
(B) Participants	2a(1)(B)	7496485	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		7505335
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		7505335

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		
(2) To insurance carriers for the provision of benefits	2e(2)	7330374	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		7330374
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	36485	
(3) Recordkeeping fees	2i(3)	97548	
(4) IQPA audit fees	2i(4)	14500	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	6326	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	5386	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		160245
j Total expenses. Add all expense amounts in column (b) and enter total	2j		7490619

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		14716
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) ☒ Unmodified (2) ☐ Qualified (3) ☐ Disclaimer (4) ☐ Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) ☐ DOL Regulation 2520.103-8 (2) ☐ DOL Regulation 2520.103-12(d) (3) ☒ neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **L.M. HENDERSON & COMPANY, LLP**

(2) EIN: **20-5520612**

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) ☐ This form is filed for a CCT, PSA, DCG or MTIA. (2) ☐ It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)			
4a			
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
4b			
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
4c			
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
4d			
e Was this plan covered by a fidelity bond?	X		500000
4e			
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?			
4f			
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?			
4g			
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?			
4h			
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)		X	
4i			
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
4j			
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?			
4k			
l Has the plan failed to provide any benefit when due under the plan?			
4l			
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
4m			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			
4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?..... ☐ Yes ☐ No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ☐ Yes ☐ No ☐ Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

Association Health & Welfare VEBA Master Trust d/b/a Indiana Employers Trust

FINANCIAL STATEMENTS

Years Ended November 30, 2025 and November 30, 2024



Association Health & Welfare VEBA Master Trust d/b/a Indiana Employers Trust

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November 30, 2025 and November 30, 2024

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Notes to Financial Statements	4 - 6

Note: All other schedules required by Section 2520.103-10 of the Department of Labor’s Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 have been omitted because they are not applicable.



L. M. HENDERSON & COMPANY LLP
CERTIFIED PUBLIC ACCOUNTANTS

450 E. 96th Street, Suite 200
Indianapolis, IN 46240
Telephone: 317.566.1000
Fax: 317.566.1700

Independent Auditor's Report

Board of Trustees
Association Health & Welfare VEBA Master Trust
d/b/a Indiana Employers Trust

Opinion

We have audited the accompanying statements of net assets available for benefits of the Association Health & Welfare VEBA Master Trust d/b/a Indiana Employers Trust (an employee benefit plan), which comprise the statements of net assets available for benefits as of November 30, 2025 and November 30, 2024, and the related statements of changes in net assets available for benefits for the years then ended and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Association Health & Welfare VEBA Master Trust d/b/a Indiana Employers Trust as of November 30, 2025 and November 30, 2024, and the changes in net assets available for benefits for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Association Health & Welfare VEBA Master Trust d/b/a Indiana Employers Trust and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Association Health & Welfare VEBA Master Trust d/b/a Indiana Employers Trust's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

Management is also responsible for maintaining a current plan instrument, including all plan amendments, administering the plan, and determining that the plan's transactions that are presented and disclosed in the financial statements are in conformity with the plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Association Health & Welfare VEBA Master Trust d/b/a Indiana Employers Trust's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Association Health & Welfare VEBA Master Trust d/b/a Indiana Employers Trust's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

L.M. Henderson & Company, L.L.P.

Certified Public Accountants
Indianapolis, Indiana

June 24, 2026

Association Health & Welfare VEBA Master Trust
d/b/a Indiana Employer's Trust

Statements of Net Assets Available for Benefits

at November 30, 2025 and November 30, 2024

	November 30, 2025	November 30, 2024
<u>ASSETS</u>		
Cash - checking and savings	\$ 351,547	\$ 297,439
Member contributions receivable	2,297	2,685
Premiums receivable	6,894	49,352
Prepaid expense	550	703
Total assets	361,288	350,179
<u>LIABILITIES</u>		
Accounts payable	25,945	36,196
Deferred premium income	51,821	45,177
Total liabilities	77,766	81,373
<u>NET ASSETS AVAILABLE FOR BENEFITS</u>	<u>\$ 283,522</u>	<u>\$ 268,806</u>

Association Health & Welfare VEBA Master Trust
d/b/a Indiana Employer's Trust

Statements of Changes in Net Assets Available for Benefits

Years Ended November 30, 2025 and November 30, 2024

	Year Ended	
	November 30, 2025	November 30, 2024
<u>ADDITIONS:</u>		
Member contributions	\$ 7,505,335	\$ 9,998,956
<u>DEDUCTIONS:</u>		
Premiums	7,330,374	9,756,496
Administrative fees	36,485	52,387
Consulting and professional fees	112,048	154,415
Bank service charges	6,326	6,370
Insurance expense	5,386	5,389
Total deductions	7,490,619	9,975,057
<u>NET INCREASE</u>	14,716	23,899
<u>NET ASSETS AVAILABLE FOR BENEFITS:</u>		
Balance, beginning of year	268,806	244,907
Balance, end of year	\$ 283,522	\$ 268,806

Association Health & Welfare VEBA Master Trust d/b/a Indiana Employers Trust

Notes to the Financial Statements

November 30, 2025 and November 30, 2024

Note 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies followed by Association Health & Welfare VEBA Master Trust d/b/a Indiana Employers Trust (the Plan) are listed below:

Basis of Accounting:

Assets and liabilities and income and expense are recognized on the accrual basis of accounting.

Basis of Presentation

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the Trustees to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Premium Receivables and Allowance for Doubtful Accounts

The Plan follows Financial Accounting Standards Board's (FASB) Accounting Standards Update (ASU) 2016-13, *Measurement of Credit Losses on Financial Instruments*. The standard requires recognition of an allowance that reflects a current estimate of credit losses expected to be incurred over the life of the asset. Collections and payments from the contributing employers are continuously monitored and credit losses are estimated relating to the Plan's receivables based on a number of factors, including the age of receivable balances, history of losses, expectations of future credit losses, and the contributing employers' ability to pay their obligations.

Premiums receivable consist of amounts billed to participating employers and are carried at original invoice amount less an estimate made for doubtful receivables based on a review of all outstanding amounts on a regular basis. As of November 30, 2025, November 30, 2024 and December 1, 2023, all receivables were deemed fully collectible and no allowance for uncollectible receivables were recorded. Premium receivables were \$6,894 and \$49,352 for the years ended November 30, 2025 and November 30, 2024, respectively.

Cash and Cash Equivalents

The Plan maintains cash balances with financial institutions which may exceed the Federal Deposit Insurance Corporation limit of \$250,000.

Subsequent Events

Management has evaluated subsequent events through June 24, 2026, the date that the financial statements were available to be issued.

Note 2: DESCRIPTION OF PLAN

The Plan began operating January 1, 2014 and is a group insurance arrangement whereby multiple associations participate in the Plan that provides fully insured health, dental, vision, and prescription drug benefits, as well as life and AD&D insurance benefits through insurance companies to employees and their dependents of employers who participate. Coverage is also available to certain employees who have separated from service under the COBRA provisions of federal law. Complete descriptions are set forth in the Summary of Benefits that can be obtained from the Plan administrator. The Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Association Health & Welfare VEBA Master Trust d/b/a Indiana Employers Trust

Notes to the Financial Statements

November 30, 2025 and November 30, 2024

Note 3: CONTRIBUTIONS AND PREMIUM PAYMENT

Contributions from employers and employees are recognized as revenue when insurance premiums become due. Total premiums of \$7,505,335 and \$9,998,956 were recognized during the years ended November 30, 2025 and November 30, 2024, respectively, which also include contributions for accidental death and dismemberment, life, vision, medical, dental, and COBRA insurance premiums.

Note 4: TAX STATUS

The Plan obtained its latest determination letter on November 6, 2014, in which the Internal Revenue Service stated that the Plan was in compliance with the applicable requirements of the Internal Revenue Code pursuant to Section 501(c)(9). The Plan has been amended since receiving the determination letter. However, the Plan administrator and the Plan's tax counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code.

In accordance with Section 419A of the Internal Revenue Code, the Plan is subject to Plan tax rates on net income earned from unrelated business activities. As the Plan is a fully insured Voluntary Employee Beneficiary Association, investment income less related investment fees are subject to tax, excluding investment income (if any exists) from tax exempt sources. For the years ended November 30, 2025 and November 30, 2024, the Plan did not incur any Federal or State income tax expense.

Management evaluates all significant income tax positions that it takes. For the years ended November 30, 2025 and November 30, 2024, management does not believe that it has taken any tax positions that would require the recording of any additional tax liability nor does it believe that there are any unrealized tax benefits that would either increase or decrease within the next twelve months. The Plan recognizes interest and penalties, if any, related to unrecognized tax benefits in interest expense. No interest or penalties have been accrued or charged to expense for uncertain tax positions for the years ended November 30, 2025 and November 30, 2024.

The tax returns of the Plan are subject to examination by the taxing authority, generally for a period of three years from the date the tax returns were filed.

Note 5: PLAN TERMINATION

The Plan's Trustees intend to operate the Plan as designed indefinitely and have not expressed any intent to terminate the Plan. but they have the right to do so at any time. In the event of termination, the Trustees of the Plan will use the assets to pay any and all expenses properly chargeable against the Plan. Any assets remaining shall be applied to provide, through the purchase of insurance, life, medical, accident or other benefits within the meaning of, and in accordance with Sections 501(c)(9), of the Internal Revenue Code.

Association Health & Welfare VEBA Master Trust d/b/a Indiana Employers Trust

Notes to the Financial Statements

November 30, 2025 and November 30, 2024

Note 6: PLAN FUNDING POLICY

The Plan's funding policy is to select contribution rates which will allow for the timely payment of benefits and provide the reserves necessary to meet extraordinary expenditures.

Note 7: PARTY-IN-INTEREST TRANSACTIONS

Fees paid by the Plan during the years ended November 30, 2025 and November 30, 2024, for services rendered by parties-in-interest, were based on contractual rates for their services.

Note 8: CONCENTRATION OF CREDIT RISK AND ECONOMIC DEPENDENCY

In accordance with the Financial Accounting Standards Board's Accounting Standards Codification (ASC) 825-10-50-20, credit risk is the possibility that a loss may occur from the failure of another party to perform according to the terms of a contract. Bank deposits are federally insured up to \$250,000 for each account owned at a federally insured bank. The following are deposits in excess of federally insured limits for the years ended November 30, 2025 and November 30, 2024, respectively:

	November 30, 2025	November 30, 2024
Deposits	\$ 351,547	\$ 297,439
Federally insured	<u>250,000</u>	<u>250,000</u>
Deposits in excess of federally insured limits	<u>\$ 101,547</u>	<u>\$ 47,439</u>

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 4085 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. 1510-0110 1510-0083 2024 This Form is Open to Public Inspection
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Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning 12/01/2024 and ending 11/30/2025

- A** This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- ☐ a single-employer plan ☒ a DFE (specify) G
- 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..... ☐ the DFVC program
- D** Check box if filing under: ☒ Form 5568 ☐ automatic extension
- ☐ 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 ASSOCIATION HEALTH AND WELFARE VERA MASTER TRUST	1b Three-digit plan number (PN) ▶ 501
	1c Effective date of plan 01/01/2014
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) SHEPHERD INSURANCE 9600 BROWNSBORO ROAD SUITE 300 LOUISVILLE KY 40241	2b Employer Identification Number (EIN) 46-7130790
	2c Plan Sponsor's telephone number 502-499-6880
	2d Business code (see instructions)

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		<u>08/24/2024</u> Date	STEPHEN GREGORY Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE		<u>08/24/2024</u> Date	STEPHEN GREGORY Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the instructions for Form 5500.

Form 5500 (2024)

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**

697

6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).**a(1)** Total number of active participants at the beginning of the plan year**6a(1)**

695

a(2) Total number of active participants at the end of the plan year**6a(2)**

471

b Retired or separated participants receiving benefits**6b**

1

c Other retired or separated participants entitled to future benefits**6c**

0

d Subtotal. Add lines 6a(2), 6b, and 6c.**6d**

472

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.**6e****f** Total. Add lines 6d and 6e.**6f****g(1)** Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)**6g(1)****g(2)** Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)**6g(2)****h** Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested**6h****7** Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)**7****8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

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

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

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 4
(4) ☒ C (Service Provider Information)
(5) ☒ D (DFE/Participating Plan Information)
(6) ☐ G (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____