

<div>Form 5500</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Annual Return/Report of Employee Benefit Plan</div> <div>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).</div> <div>▶ Complete all entries in accordance with the instructions to the Form 5500.</div>	<div>OMB Nos. 1210-0110 1210-0089</div> <div>2025</div> <div>This Form is Open to Public Inspection</div>
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Part I	Annual Report Identification Information
For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025	
A	This return/report is for: <div><div>☐ a multiemployer plan</div><div>☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)</div><div>☒ a single-employer plan</div><div>☐ a DFE (specify) _____</div></div>
B	This return/report is: <div><div>☒ the first return/report</div><div>☐ the final return/report</div><div>☒ an amended return/report</div><div>☐ a short plan year return/report (less than 12 months)</div></div>
C	If the plan is a collectively-bargained plan, check here. ▶ ☐
D	Check box if filing under: <div><div>☐ Form 5558</div><div>☐ automatic extension</div><div>☐ the DFVC program</div><div>☐ special extension (enter description)</div></div>
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 2025 GROUP SHORT-TERM DISABILITY INSURANCE
1b	Three-digit plan number (PN) ▶ 123
1c	Effective date of plan 01/01/2025
2a	Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) DREISON INTERNATIONAL 4540 W 160TH ST CLEVELAND, OH 44135-26284540 W 160TH ST CLEVELAND, OH 44135-2628
2b	Employer Identification Number (EIN) 34-1516480
2c	Plan Sponsor's telephone number 567-674-4449
2d	Business code (see instructions) 333310

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	07/13/2026	NANCY SINNETT
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/13/2026	ERICA BOKISA
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☐ Same as Plan Sponsor UNITED OF OMAHA LIFE INSURANCE COMPANY 3300 MUTUAL OF OMAHA PLAZA OMAHA, NE 68175-1004	3b Administrator's EIN 47-0322111 3c Administrator's telephone number 800-655-5142 <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
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 DREISON INTERNATIONAL c Plan Name 2025 GROUP SHORT-TERM DISABILITY INSURANCE	4b EIN 47-0322111 4d PN
5 Total number of participants at the beginning of the plan year	5 103
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year 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.....	<div style="background-color: #cccccc; height: 20px; width: 100%;"></div> <div style="display: flex; justify-content: space-between;">6a(1) 103</div> <div style="display: flex; justify-content: space-between;">6a(2) 103</div> <div style="display: flex; justify-content: space-between;">6b</div> <div style="display: flex; justify-content: space-between;">6c</div> <div style="display: flex; justify-content: space-between;">6d 103</div> <div style="display: flex; justify-content: space-between;">6e</div> <div style="display: flex; justify-content: space-between;">6f 103</div> <div style="display: flex; justify-content: space-between;">6g(1)</div> <div style="display: flex; justify-content: space-between;">6g(2)</div> <div style="display: flex; justify-content: space-between;">6h</div>
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 1I b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: 4B	
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) ☐ **C** (Service Provider Information)
- (5) ☐ **D** (DFE/Participating Plan Information)
- (6) ☐ **G** (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code _____

February 11, 2026

**DREISON INTERNATIONAL
4540 W 160TH ST
CLEVELAND, OH 44135**

Re: Certified Information for Department of Labor
Form 5500, Schedule A – Group Number(s):
GLTD0BTH4 GLUG0BTH4
GUG 0BTH4 GVTL0BTH4

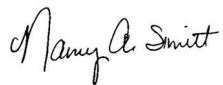
GUC 0BTH4

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

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

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

Sincerely,



Nancy A. Sinnett
Vice President
Finance Operations

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

**DREISON INTERNATIONAL
CLEVELAND, OH**

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000BTH4
Legacy Group ID: GLTD0BTH4
Type of Contract: NON-RETENTION
Data for Period: 01-01-2025 to 01-01-2026

Benefits Provided	Persons Covered
Long Term Disability Insured	67

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
C & A BENEFITS GROUP LLC 475 METRO PL S STE 210 DUBLIN, OH 43017	1,667		Agent or Broker of Record	3
DMC BENEFITS INC 1485 PRINCE CHARLES AVE WESTLAKE, OH 44145	0	1,296	Other Compensation	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums	18,521
Memo Items: Benefit Charges – Claims Paid	0
Administrative Service Fees	0

Group Office: CINCINNATI

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

**DREISON INTERNATIONAL
CLEVELAND, OH**

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000BTH4
Legacy Group ID: GLUG0BTH4
Type of Contract: NON-RETENTION
Data for Period: 01-01-2025 to 01-01-2026

Benefits Provided	Persons Covered
Life & AD&D	102

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
C & A BENEFITS GROUP LLC 475 METRO PL S STE 210 DUBLIN, OH 43017	2,263		Agent or Broker of Record	3
DMC BENEFITS INC 1485 PRINCE CHARLES AVE WESTLAKE, OH 44145	0	1,440	Other Compensation	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums	20,569
Memo Items: Benefit Charges – Claims Paid	0
Administrative Service Fees	0

Group Office: CINCINNATI

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

**DREISON INTERNATIONAL
CLEVELAND, OH**

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000BTH4
Legacy Group ID: GUC 0BTH4
Type of Contract: NON-RETENTION
Data for Period: 01-01-2025 to 01-01-2026

Benefits Provided	Persons Covered
ShortTerm Disability Voluntary	4

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
C & A BENEFITS GROUP LLC 475 METRO PL S STE 210 DUBLIN, OH 43017	271		Agent or Broker of Record	3
DMC BENEFITS INC 1485 PRINCE CHARLES AVE WESTLAKE, OH 44145	0	190	Other Compensation	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums	2,707
Memo Items: Benefit Charges – Claims Paid	0
Administrative Service Fees	0

Group Office: CINCINNATI

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

**DREISON INTERNATIONAL
CLEVELAND, OH**

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000BTH4
Legacy Group ID: GUG 0BTH4
Type of Contract:
Data for Period: 01-01-2025 to 01-01-2026

Benefits Provided	Persons Covered
Short Term Disability Insured	103

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
C & A BENEFITS GROUP LLC 475 METRO PL S STE 210 DUBLIN, OH 43017	2,597		Agent or Broker of Record	3
DMC BENEFITS INC 1485 PRINCE CHARLES AVE WESTLAKE, OH 44145	0	1,818	Other Compensation	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 25,969

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

Group Office: CINCINNATI

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

**DREISON INTERNATIONAL
CLEVELAND, OH**

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000BTH4
Legacy Group ID: GVTL0BTH4
Type of Contract: NON-RETENTION
Data for Period: 01-01-2025 to 01-01-2026

Benefits Provided	Persons Covered
Life & AD&D Voluntary	31

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
C & A BENEFITS GROUP LLC 475 METRO PL S STE 210 DUBLIN, OH 43017	4,141		Agent or Broker of Record	3
DMC BENEFITS INC 1485 PRINCE CHARLES AVE WESTLAKE, OH 44145	0	1,933	Other Compensation	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 27,608

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

Group Office: CINCINNATI

FORM 5500 ACKNOWLEDGEMENT

Client Name: Dreison International (Maradyne & DCM)

Plan Sponsor: _____

Plan Year: 2025 **Date:** 7/13/2026

The undersigned acknowledges receipt of information regarding the **Form 5500 filing requirements** administered by the U.S. Department of Labor and the Internal Revenue Service.

The undersigned understands that:

- Form 5500 is an **annual filing requirement** applicable to certain ERISA-covered employee benefit plans.
- The filing deadline is the **last day of the seventh month following the end of the plan year** (e.g., July 31 for calendar-year plans).
- Failure to file Form 5500 timely or accurately may result in **significant penalties**, including penalties exceeding **\$2,000 per day**.

☒ **Option 1 – Engage C&A to Prepare and File Form 5500**

By selecting this option, you authorize **C&A** to prepare and electronically file the applicable Form 5500(s) on your behalf, subject to receipt of all required and accurate plan and participant data in a timely manner. Annual fee of \$1,000 per FEIN

You understand that C&A's ability to meet filing deadlines is dependent upon the timely cooperation and information provided by the plan sponsor.

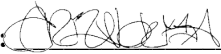
☐ **Option 2 – Client Will File Form 5500 Independently**

By selecting this option, you acknowledge that:

- You have been advised of the Form 5500 filing requirements and associated penalties.
- You are assuming full responsibility for the preparation, accuracy, and timely submission of all required Form 5500 filings.
- **C&A will not be responsible** for missed deadlines, incomplete filings, or penalties resulting from filings performed independently by the plan sponsor.

Certification

By signing below, I certify that I am an authorized representative of the plan sponsor and that the selection indicated above accurately reflects the plan sponsor's election regarding Form 5500 filing responsibilities.

Authorized Signature: 

Printed Name: Erica Bokisa

Title: HR Manager

Date: 7/13/2026