Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2025

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

A This return/report is for:
- [ ] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- [X] a single-employer plan
- [ ] a DFE (specify) _____

B This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [X] 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
AF HOLDING CO. EMPLOYEE HEALTH AND WELFARE BENEFITS PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/2021

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)
AF HOLDING CO

DANIEL FRERICHS

809 S HAMILTON ST
SULLIVAN, IL 61951-2209

809 S HAMILTON ST
SULLIVAN, IL 61951-2209

2b Employer Identification Number (EIN)
37-1387036

2c Plan Sponsor's telephone number
217-728-8388

2d Business code (see instructions)
332900

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.	10/15/2026	DAN FRERICHS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2026	DAN FRERICHS
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

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

a Sponsor's name

4b EIN

c Plan Name

4d PN

5	Total number of participants at the beginning of the plan year	**5**	320
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)**	320
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	299
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	299
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	299
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

4B 4D 4E 4H 4G

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [ ] **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_____

PLAN INFORMATION REPORT FOR THE PERIOD OF 1/1/2025 TO 12/31/2025

LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION

IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500

IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: AF HOLDING COMPANY

PART I

1) COVERAGE - LIFE INSURANCE

a) CARRIER:	Standard Insurance Company
b) EIN:	93-0242990
c) NAIC CODE:	000-69019
d) CONTRACT NUMBER:	166591
e) NUMBER OF PERSONS COVERED:	296
f) FROM:	1/1/2025
g) TO:	12/31/2025

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID:	$3,636.90
FEES PAID / AMOUNT:	$0.00

A) NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID	B) AMOUNT OF COMMISSION PAID			FEES PAID		E) ORG. CODE
	COMM.	CONT. COMP*	GA OVR.	C) AMOUNT	D) PURPOSE	
FIRST MID INSURANCE GROUP INC 1520 CHARLESTON AVE MATTOON, IL 61938	$3,636.90	$0.00	$0.00	$0.00		3

TOTAL COMMISSIONS PAID	$3,636.90
TOTAL CONTINGENT COMP PAID	$0.00
TOTAL GA OVERRIDES PAID	$0.00

"Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

PLAN INFORMATION REPORT FOR THE PERIOD OF 1/1/2025 TO 12/31/2025

LONG FORM INFORMATION

PART III - 166591

7) BENEFIT TYPE: LIFE INSURANCE

EXPERIENCE RATED CONTRACTS

a) PREMIUMS: (1) AMOUNT RECEIVED:	$84,947.77	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID:	($1,262.00)	
(3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE:	$0.00	
(4) EARNED PREMIUM ((1)+(2) - (3)):		$83,685.77
b) BENEFIT CHARGES: (1) CLAIMS PAID:	$25,000.00	
(2) INCREASE (DECREASE) CLAIM RESERVES:	$139,751.00	
(3) INCURRED CLAIMS ((1)+(2)):		$164,751.00
(4) CLAIMS CHARGED:		$164,751.00
c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:		
(A) COMMISSIONS:	$3,636.90	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES:	$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS:	$0.00	
(D) OTHER EXPENSES:	$8,798.27	
(E) TAXES:	$410.76	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES:	$5,817.24	
(G) OTHER RETENTION CHARGES:	$0.00	
(H) TOTAL RETENTION:		$18,663.17
cl) DIVIDEND OR RETROACTIVE RATE REFUND:		
d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR		
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT		$ 0.00
(2) CLAIM RESERVES:		$0.00
(3) OTHER RESERVES:		$0.00
dl) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE:		$0.00

Standard Insurance Company HEREBY CERTIFIES THAT THIS INFORMATION IS COMPLETE AND ACCURATE

PLAN INFORMATION REPORT FOR THE PERIOD OF 1/1/2025 TO 12/31/2025

LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION

IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500

IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: AF HOLDING COMPANY

PART I

1) COVERAGE - LONG TERM DISABILITY

a) CARRIER:	Standard Insurance Company
b) EIN:	93-0242990
c) NAIC CODE:	000-69019
d) CONTRACT NUMBER:	166591
e) NUMBER OF PERSONS COVERED:	174
f) FROM:	1/1/2025
g) TO:	12/31/2025

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID:	$3,924.45
FEES PAID / AMOUNT:	$0.00

A) NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID	B) AMOUNT OF COMMISSION PAID			FEES PAID		E) ORG. CODE
	COMM.	CONT. COMP*	GA OVR.	C) AMOUNT	D) PURPOSE	
FIRST MID INSURANCE GROUP INC 1520 CHARLESTON AVE MATTOON, IL 61938	$3,924.45	$0.00	$0.00	$0.00		3

TOTAL COMMISSIONS PAID	$3,924.45
TOTAL CONTINGENT COMP PAID	$0.00
TOTAL GA OVERRIDES PAID	$0.00

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

PLAN INFORMATION REPORT FOR THE PERIOD OF 1/1/2025 TO 12/31/2025

LONG FORM INFORMATION

PART III - 166591

7) BENEFIT TYPE: LONG TERM DISABILITY

EXPERIENCE RATED CONTRACTS

a) PREMIUMS: (1) AMOUNT RECEIVED:	$40,946.13	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID:	($295.00)	
(3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE:	$0.00	
(4) EARNED PREMIUM ((1)+(2) - (3)):		$40,651.13
b) BENEFIT CHARGES: (1) CLAIMS PAID:	$19,470.67	
(2) INCREASE (DECREASE) CLAIM RESERVES:	$84,341.30	
(3) INCURRED CLAIMS ((1)+(2)):		$103,811.97
(4) CLAIMS CHARGED:		$103,811.97
c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:		
(A) COMMISSIONS:	$3,924.45	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES:	$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS:	$0.00	
(D) OTHER EXPENSES:	$7,931.62	
(E) TAXES:	$162.59	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES:	$4,561.00	
(G) OTHER RETENTION CHARGES:	$0.00	
(H) TOTAL RETENTION:		$16,579.66
cI) DIVIDEND OR RETROACTIVE RATE REFUND:		
d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR		
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT		$ 0.00
(2) CLAIM RESERVES:		$0.00
(3) OTHER RESERVES:		$0.00
dI) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE:		$0.00

Standard Insurance Company HEREBY CERTIFIES THAT THIS INFORMATION IS COMPLETE AND ACCURATE

vsp
vision care

SCHEDULE A (Form 5500) Insurance Information

If Schedule A information is required to file a complete Form 5500 or Form 5500 C/R, information from this form must be transcribed onto IRS Schedule A (Form 5500) Insurance Information form (Cat. No. 13505I) as required by federal regulation.

AF HOLDING CO
LORI POORMAN
811 S HAMILTON ST
SULLIVAN IL 61951-2209

Group No: **30107836**
Ins. Carrier: Vision Service Plan
Ins. Carrier NAIC Code No: **12516**
Ins. Carrier FEIN: **200891619**
Benefit Type: Vision Care
Policy or Contract Year: **01/01/2025 - 12/31/2025**

Group Legal Name and Address:

AF HOLDING CO
811 S HAMILTON ST
SULLIVAN IL 61951-2209

Approximate Number of Persons Covered at the End of Policy or Contract Year: **293**

Fees, Payments, Claims

Total Administrative Fees Paid to Carrier:	**$14,530.05**
Total Payments Made to Carrier:	**$40,360.94**
Total Claims Paid by Carrier:	**$22,412.16**

Insurance Fees and Commissions Paid to Agents and Brokers:

Agent or Broker	Commissions/Fees Paid for Policy or Contract Year
First Mid Insurance Group I **PO BOX 14** **FORSYTH IL 62535-0014**	**$1,633.35**

IF YOU HAVE QUESTIONS REGARDING THE TRANSPOSITION OF INFORMATION CONTAINED IN THIS REPORT, CONTACT YOUR INTERNAL COMPLIANCE OFFICE.

Vision Service Plan hereby certifies that this statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate as of 2/6/2026.

EXDM5500/**U-3909/30107836/1/20260206**

Received
2/17/26
C. Smith