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

2018

This Form is Open to **Public Inspection**

Par	t I Annual Report Identification Inf	ormation		<u>'</u>	•						
F	For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018										
A T	nis return/report is for: a multiemployer plan										
				mation in accordance with the fo							
_	a single-employer	plan 📗 a	DFE (specify)		•						
B TI	nis return/report is: the first return/rep		e final return/report	_							
an amended return/report a short plan year return/report (less than 12 months)											
	e plan is a collectively-bargained plan, check here										
D C	heck box if filing under: X Form 5558	O T TO ST THE TOTAL THE TO	itomatic extension	the DFVC program							
Par	special extension (enter description)									
	and the state of t	equested information									
	lame of plan	OE BUE DESC	- ADDT ADD A	1b Three-digit							
RES	URANCE AND BENEFITS TRUST EARCH ASSOCATION OF CALIFO	OF THE PEAC	E OFFICERS	plan number (PN)	501						
				1c Effective date of plan 06/21/1991							
	lan sponsor's name (employer, if for a single-employer pl			2b Employer Identification Nu	ımber (EIN)						
	lailing address (include room, apt., suite no. and street, or			68-6068469							
TNIC	ity or town, state or province, country, and ZIP or foreign	postal code (if foreign, se	e instructions)	2c Plan Sponsor's telephone	number						
TMD	URANCE AND BENEFITS TRUST	OF THE PORA	.C	8006556397							
				2d Business code (see instru	ctions)						
401	O TRUXEL ROAD			525100							
SAC	RAMENTO CA	95834-3725			ALTINOSIMI I						
		0004 0720			There's a li						
					at Au III						
Cautio	n: A penalty for the late or incomplete filing of th	nis return/report will t	pe assessed unless reas	onable cause is established.							
Under pe	nalties of perjury and other penalties set forth in the instructions, I de	clare that I have examined this	return/report_including accompar		s, as well						
as the el	ectronic version of this return/report, and to the best of my knowledge	and belief, it is true, correct, a	and complete								
SIGN	Kha Ann	INIEJA	TORY SCA	ILEMAKA							
HERE	Signature of plan administrator	Date	Enter name of individual	signing as plan administrator							
				organing as plan auministrator							
SIGN											
HERE	Signature of employer/plan sponsor	Date	Enter name of individual	signing as employer or plan spo	nsor						
CIOL				magazina arriprojer er piarr opo							
SIGN											
	Signature of DFE	Date	Enter name of individual	signing as DFE							
or Da	nerwork Reduction Act Notice, see the Instruction	f F									

Form 5500 (2018) v. 171027

	Form 5500 (2018)					Pa	ge 2				
3a	Plan administrator's name and address 🗵 Same as Plan Sponsor					3b Administrator's EIN					
	20							istrator's telephone number			
							3C Adminis	trator's	telephone n	umber	
						_ h					
						- 1					
4	If the name and/or EIN of the plan sponsor or the plan name has change	ed since	the	las	t return/re	eport	filed for this p	lan,	4b _{EIN}		
	enter the plan sponsor's name, EIN, the plan name and the plan number	from th	e las	st r	eturn/rep	ort:			4 4		
	Sponsor's name								4d PN		
C	Plan Name										
5	Total number of participants at the beginning of the plan year							5		65576	
6	Number of participants as of the end of the plan year unless otherwise s	tated (w	elfar	re p	olans com	nplete	only lines				
	6a(1), 6a(2), 6b, 6c, and 6d).										
	(1) Total number of active participants at the beginning of the plan year							6a(1)		58001	
	(2) Total number of active participants at the end of the plan year							6a(2)		59919	
D	Retired or separated participants receiving benefits							6b 6c			
	Other retired or separated participants entitled to future benefits Subtotal. Add lines 6a(2), 6b, and 6c							6d		59919	
	Deceased participants whose beneficiaries are receiving or are entitled t							6e		33313	
	Total. Add lines 6d and 6e							6f			
	Number of participants with account balances as of the end of the plan										
	complete this item)							6g			
n	Number of participants who terminated employment during the plan year							6h			
7	less than 100% vested Enter the total number of employers obligated to contribute to the plan (011			
•	this item)			•			•	7		200	
8a	If the plan provides pension benefits, enter the applicable pension feature							cs Code	s in the inst	ructions:	
	If the plan provides welfare benefits, enter the applicable welfare feature ${\bf 4F}$ ${\bf 4H}$ ${\bf 4L}$	codes f	rom	th	e List of F	Plan C	Characteristics	Codes	in the instru	uctions:	
40	ar an an										
9a	Plan <u>fu</u> nding arrangement (check all that apply)	9b F	Plan	be	nefit arraı	ngem	ent (check all	that ap	oly)		
	(1) X Insurance	(1)	X	Insuran	ce	(,,		
	(2) Code section 412(e)(3) insurance contracts		2)	Ц			412(e)(3) inst		contracts		
	(3) X Trust	(3)	X	Trust						
10	(4) General assets of the sponsor		4)	Ц			ts of the spon				
10	Check all applicable boxes in 10a and 10b to indicate which schedules a (See instructions)	are attac	ched	, aı	nd, where	e indic	cated, enter th	ie numb	er attached		
а	Pension Schedules	b d	Gene	era	l Schedu	ıles					
	(1) R (Retirement Plan Information)			X		Н	(Financial Int	ormatio	n)		
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money		2)			ı	(Financial Int		,	an)	
	Purchase Plan Actuarial Information) - signed by the plan		3)	X	5	Α	(Insurance Ir	nformati	on)		
	actuary	(4)	X		С	(Service Pro	vider Inf	ormation)		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		5)	Н		D	(DFE/Particip	-		-	
	Information) - signed by the plan actuary	(6)	Ц		G	(Financial Tra	ansactio	on Schedule	es)	

Form 5500 (2018) Page **3**

Pai	t 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	Vo
	Enter the Receipt Confirmation Code for the 2018 Form M-1 annual report. If the plan was not required to file the 2018 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. (Failute to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)	
	Receipt Confirmation Code	

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

OMB No. 1210-0110

2018

This Form is Open to

		ри	irsuant to	ERISA s	ection 103(a)(2).			Pub	lic Inspection	
For calendar plan year 20	18 or fiscal plan	year beginning 01/0	1/201	8	and endir	ıg	12/31	/2018		
A Name of plan	•					Вт	hree-digit			
	ND BENE	TITS TRUST OF T	HE PE	EACE	OFFICERS		lan number (PN)	501	
							,			
C Plan sponsor's nai	me as shown c	n line 2a of Form 5500				D E	mplover Ider	ntification	Number (EIN)	
•		TITS TRUST OF T	HE PO	DRAC				06846		
Part I Inform	nation Cond	erning Insurance Cor	ntract C	overaç	ge, Fees, and C	omm	issions F	rovide inf	ormation for each	
		Schedule A. Individual cont								
Coverage Informat	tion:						<u> </u>			
<u> </u>									_	
(a) Name of insurance	e carrier									
RELIASTAR L	IFE INSU	JRANCE COMAPNY	OF NE	W YC	RK - LIFE					
4.) 5111	(c) NAIC	(d) Contract or	(e)	Approxi	mate number of per	sons	Р	olicy or co	ntract year	
(b) EIN	code	identification number			of policy or contra		(f) F		(g) To	
							(.,,		(3)	
41-0451140	67105	66326-3				951	10/01	/2017	09/30/2018	
_										
in descending orde			oo ana tot	a. 00	icolorio pala. Lict iri		io agonto, bi	onoro, am	a carror percente	
(a) ⁻	Total amount o	f commissions paid			(b)	Total a	mount of fees	s paid		
		6	0037						117976	
Persons receiving	commissions a	and fees. (Complete as many		s needed	to report all persor	ns)				
T Greene receiving		nd address of the agent, bro			•		r fees were r	naid		
MEYERS-STEV		OOHEY CO INC	,	, o. po.o.		0.0	, , , o o o , , o , o , o		_	
26101 MARQU										
MISSION VĨE		CA 926	92							
									(e)	
(b) Amount of sale			Fees	and oth	er commissions pai	d			Organization	
commission	s paid	(c) Amount			(d) Purp	ose			code	
		, ,	ADMIN	FEE	S					
		117976							3	
	(a) Name a	nd address of the agent, bro	ker. or oth	ner perso	n to whom commis	sions o	r fees were r	aid		
MEYERS-STEV		OOHEY CO INC	,							
26101 MARQU	ERITE PE	YWY								
MISSION VIE		CA 926	92							
									(e)	
(b) Amount of sales and base Fees and other commissions paid Organization						Organization				
commission	s paid	(c) Amount			(d) Purp	ose			code	
		` '	WRITI	NG A	GENT					
	60037			_					3	
		•								

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

Schedule A (Form 5500) 2018 v. 171027

Schedule A (Form 5500) 2018	3	Page 2-	
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base commissions paid			(e) Organization
	(c) Amount	(d) Purpose	code
(a) Name an	d address of the agent, bro	Dker, 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
Commissions paid	(c) Amount	(d) Purpose	code
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purnose	code

(d) Purpose

(c) Amount

Pa	art II Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of su purposes of this report.	ch individual contracts with each o	carrier ma	ay be treated as a unit for
4	Current value of plan's interest under this contract in the general account	at year end	. 4	
	Current value of plan's interest under this contract in separate accounts a	t year end	. 5	
6	Contracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
	If the carrier, service, or other organization incurred any specific costs in			
	the acquisition or retention of the contract or policy, enter amount		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group defen	red annuity		
	(3) other (specify)			
				_
f	If contract purchased, in whole or in part, to distribute benefits from a te	erminating plan, check here	>	
7	Contracts With Unallocated Funds (Do not include portions of these cor	tracts maintained in separate acc	ounts)	
а	Type of contract: (1) deposit administration (2)	immediate participation guarar	ntee	
	(3) guaranteed investment (4)	other >		
b	Balance at the end of the previous year		7b	
С	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account			
	(5) Other (specify below)	7c(5)		
	>			
_	(6) Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6))		7d	
е	2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			
	(1) Disbursed from fund to pay benefits or purchase annuities during year			
	(2) Administration charge made by carrier	7e(2)		
	(3) Transferred to separate account			
	(4) Other (specify below)	7e(4)		
	>			
			7./5	
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

Pa	art III	Welfare Benefit Contract Information							
	If more than one contract covers the same group of employees of the same employer(s) or members of the same								
	employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated								
		as a unit. Where contracts cover individual employees, th	e entire group	of such individual	contracts with	each carrier may be			
		treated as a unit for purposes of this report.							
8	Benefit an	nd contract type (check all applicable boxes)							
		ulth (other than dental or vision) b Dental		c Vision		d X Life insurance			
	H '''	- H 2011an	n disability	H ******	al unemploym	. H			
	. \square	p loss (large deductible) j HMO con	-	k PPO contrac		I Indemnity contract			
		er (specify)	itract	L FFO COMMA	J.	- Minderninty contract			
9		e-rated contracts:							
а	•	s: (1) Amount received	9a(1)						
-		ease (decrease) in amount due but unpaid							
		ease (decrease) in unearned premium reserve	0 (0)						
		ed ((1) + (2) - (3))			9a(4)				
b		narges (1) Claims paid			1 (-)				
		ease (decrease) in claim reserves							
		rred claims (add (1) and (2))			9b(3)	•			
		ns charged			9b(4)				
С		er of premium: (1) Retention charges (on an accrual basis)							
		Commissions	9c(1)(A)						
		Administrative service or other fees	9c(1)(B)						
		Other specific acquisition costs							
		Other expenses	0 - /4\/D\						
	(E)	Taxes	9c(1)(E)						
		Charges for risks or other contingencies							
	(G)	Other retention charges	9c(1)(G)						
	(H)	Total retention			9c(1)(H)				
	(2) Divid	lends 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 pro	ovide benefits	after retirement	9d(1)				
	(2) Clain	n reserves			9d(2)				
	(3) Othe	r reserves			9d(3)				
е	Dividends	or retroactive rate refunds due. (Do not include amount en	tered in line	Oc(2).)	9e				
10	-	ience-rated contracts:				1000541			
а		niums or subscription charges paid to carrier			10a	1200741			
b		ier, service, or other organization incurred any specific cost							
	-	sition or retention of the contract or policy, other than repo	rted in Part I, I	ne 2	106				
_	•	port amount			10b				
S	pecify natu	re of costs.							

Pa	rt IV Provision of Information				
11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Υ	∕es X	No	
12	If the answer to line 11 is "Yes," specify the information not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Internal Revenue Service

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

2018

This For	m is	Open	to
Public	Insp	ection	1

		Pui	oddin to	LI 1107 (300th	011 100(α)(<i>Σ</i>).			io mopostion	
For calendar plan year 20	118 or fiscal plan	year beginning 01/01	/201	8	and endin	g	12/31/2018		
A Name of plan						B Thi	ree-digit		
INSURANCE A	ND BENEF	'ITS TRUST OF T	HE PE	EACE OF	FICERS	pla	n number (PN)	501	
0									
C Plan sponsor's na		n line 2a of Form 5500 'ITS TRUST OF T	מד סמ	D A C		D Em	ployer Identification 68-6068469		
		erning Insurance Con			Fees, and C	ommis			
		Schedule A. Individual contra							
1 Coverage Information	-								
(a) Name of income									
(a) Name of insurance	e carrier								
RELIASTAR L	IFE INSU	RANCE COMAPNY	OF NE	EW YORK	C- AD&D				
		(1) 0	Ι ,,				Delieverse	ntroot voor	
(b) EIN	(c) NAIC code	(d) Contract or identification number		(e) Approximate number of person covered at end of policy or contract			Policy or co	(g) To	
					. ,		(I) FIOIII	(9) 10	
41-0451140	67105	56326-3				454	10/01/2017	09/30/2018	
2 Insurance fee and		formation. Enter the total fees	and total	al commissio	ons paid. List in l				
in descending ord									
(a)	Total amount of	commissions paid			(b) ⁷	Total am	ount of fees paid		
			246					48491	
3 Persons receiving		nd fees. (Complete as many							
MYERS-STEVE		nd address of the agent, brok	er, or oth	ner person to	whom commis	sions or	tees were paid		
26101 MARQU									
MISSION VIE		CA 9269	2						
								(e)	
(b) Amount of sale commission			Fees	and other c	ommissions paid	d		Organization	
	- Paid	(c) Amount			(d) Purp	ose		code	
			DMIN	FEE					
		48491						3	
	(a) Nama an	nd address of the agent, brok	or or oth	or poroon to	whom commiss	oione or i	food word poid		
MYERS-STEVE			er, or ou	ier person to	WHOTH COMMIS	510115 01	lees were palu		
26101 MARQU									
MISSION VIE		CA 9269	2						
(b) Amount of sale	es and base		Food	and other a	ommissions said			(e)	
commissions paid Organ							Organization		
	•	(c) Amount			(d) Purp	ose		code	
	24246	[KTTI	NG AGE	N.T.			3	
	7.47.4D	1						1 .5	

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

Schedule A (Form 5500) 2018 v. 171027

Schedule A (Form 5500) 2018	3	Page 2-	
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base commissions paid			(e) Organization
	(c) Amount	(d) Purpose	code
(a) Name an	d address of the agent, bro	Dker, 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
Commissions paid	(c) Amount	(d) Purpose	code
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
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(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
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commissions paid	(c) Amount	(d) Purnose	code

(d) Purpose

(c) Amount

Pa	art II Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of su purposes of this report.	ch individual contracts with each o	carrier ma	ay be treated as a unit for
4	Current value of plan's interest under this contract in the general account	at year end	. 4	
	Current value of plan's interest under this contract in separate accounts a	t year end	. 5	
6	Contracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
	If the carrier, service, or other organization incurred any specific costs in			
	the acquisition or retention of the contract or policy, enter amount		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group defen	red annuity		
	(3) other (specify)			
				_
f	If contract purchased, in whole or in part, to distribute benefits from a te	erminating plan, check here	>	
7	Contracts With Unallocated Funds (Do not include portions of these cor	tracts maintained in separate acc	ounts)	
а	Type of contract: (1) deposit administration (2)	immediate participation guarar	ntee	
	(3) guaranteed investment (4)	other >		
b	Balance at the end of the previous year		7b	
С	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account			
	(5) Other (specify below)	7c(5)		
	>			
_	(6) Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6))		7d	
е	2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			
	(1) Disbursed from fund to pay benefits or purchase annuities during year			
	(2) Administration charge made by carrier	7e(2)		
	(3) Transferred to separate account			
	(4) Other (specify below)	7e(4)		
	>			
			7./5	
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

Pa	rt III	Welfare Benefit Contract Information				
		If more than one contract covers the same group of emplo	oyees of the s	same employer(s) or	members of the	same
		employee organization(s), the information may be combined	-			= -
		as a unit. Where contracts cover individual employees, the	e entire group	of such individual of	contracts with ea	ch carrier may be
		treated as a unit for purposes of this report.				
8	Benefit	t and contract type (check all applicable boxes)				
		Health (other than dental or vision)		c Vision		d Life insurance
		remporary disability (accident and sickness) f Long-term	disability	g Supplement	al unemploymen	t h Prescription drug
	i ∏	Stop loss (large deductible) j HMO con	tract	k ☐ PPO contrac		I Indemnity contract
	m $\overline{\mathbf{X}}$	Other (specify) AD&D		_		
9	Experie	ence-rated contracts:				
а	Premiu	ıms: (1) Amount received	9a(1)			
	(2) In	crease (decrease) in amount due but unpaid	9a(2)			
		crease (decrease) in unearned premium reserve				
		arned ((1) + (2) - (3))			9a(4)	
b		t charges (1) Claims paid	01-747			
		crease (decrease) in claim reserves				
		curred claims (add (1) and (2))			9b(3)	
		laims charged			9b(4)	
С		nder of premium: (1) Retention charges (on an accrual basis)				
	(Δ		9c(1)(A)			
	(E		9c(1)(B)			
	(C		9c(1)(C)			
	(C		9c(1)(D)			
	(E		9c(1)(E)			
	(F		9c(1)(F)			
	(G	G) Other retention charges	9c(1)(G)			
	(⊢	l) Total retention			9c(1)(H)	
	(2) D	ividends 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 pro	vide benefits	after retirement	9d(1)	
	(2) C	laim reserves			9d(2)	
	(3) O	ther reserves			9d(3)	
<u>e</u>	Divider	nds or retroactive rate refunds due. (Do not include amount en	tered in line	9c(2).)	9e	
10	Nonex	perience-rated contracts:				
а	Total p	remiums or subscription charges paid to carrier			10a	715957
b	If the c	arrier, service, or other organization incurred any specific cost	s in connecti	on with		
	the acc	quisition or retention of the contract or policy, other than repor	ted in Part I,	line 2		
	above,	report amount			10b	
S	pecify na	ature of costs. N/A				
Da	rt IV	Provision of Information				
11			to consulate	Cabadula AQ	Пу	res X No
12		e insurance company fail to provide any information necessary		ocnedule A?	Ц Ү	es X No
12	ii the a	nswer to line 11 is "Yes," specify the information not provided	. 🖊			

Department of the Treasury Internal Revenue Service

Insurance Information

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

OMB No. 1210-0110

2018

Department of Employee Benefits Secu		▶ Fil	e as an a	ttachment to Form 5500.			
Pension Benefit Guara	-	• · · · · · · · · · · · · · · · · · · ·	•	are required to provide the in ERISA section 103(a)(2).		Public	rm is Open to Inspection
or calendar plan year 20)18 or fiscal plan	year beginning 01/01	L/201	8 and endin	g 12/31	/2018	
A Name of plan INSURANCE A	ND BENE	FITS TRUST OF T	HE PE	ACE OFFICERS	B Three-digit plan number	(PN) ▶	501
INSURANCE A	ND BENE	on line 2a of Form 5500 FITS TRUST OF T				068469	. ,
		cerning Insurance Con Schedule A. Individual contr		- '			
1 Coverage Information	tion:						
(a) Name of insurance	e carrier						
STANDARD IN		COMPANY					
(b) EIN	(c) NAIC	(d) Contract or		Approximate number of pers		olicy or con	tract year
(-,	code	identification number	covere	ed at end of policy or contract	ct year (f) F	rom	(g) To
93-0242990	69019	649401		20	825 01/01	/20181	2/31/2018
		formation. Enter the total fee	s and tota	al commissions paid. List in I	ine 3 the agents, b	rokers, and	other persons
in descending ord		_ ·		, , , , , , , , , , , , , , , , , , ,	F		
(a)	Total amount of	of commissions paid	0	(b)	Total amount of fee	s paid	0
3 Paragna regalizing	commissions	and fees. (Complete as many	_	nooded to report all person			
Persons receiving		nd address of the agent, brok			•	naid	
NONE	(a) Hamo	ina addition of the agent, brot	tor, or our	or pordorr to whom committee	510110 01 1000 11010	para	
(b) Amount of sale			Fees	and other commissions paid	d		(e) Organization
commission	is paid	(c) Amount		(d) Purp	ose	code	
	(a) Name a	nd address of the agent, brok	ker, or oth	er person to whom commiss	sions or fees were	paid	
(b) Amount of sale			Fees	and other commissions paid			(e) Organization
	•	(c) Amount		(d) Purp	ose		code
Tax Danamusuk Dadu	ation Act Nati	co soo the Instructions for	Cours EEC	20		abadula A /	Form 5500\ 2019

Schedule A (Form 5500) 2018 v. 171027

Schedule A (Form 5500) 2018	3	Page 2-	
(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 (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 (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 (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 Fees and other commissions paid (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 Fees and other commissions or fees were paid			
		<u> </u>	(e) Organization
	(c) Amount	(d) Purpose	code
(a) Name an	d address of the agent, bro	Dker, or other person to whom commissions or fees were paid	
	, , , , , , , , , , , , , , , , , , ,		
		Fees and other commissions paid	
Commissions paid	(c) Amount	(d) Purpose	code
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purnose	code

(d) Purpose

(c) Amount

Pa	art II Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of su purposes of this report.	ch individual contracts with each o	carrier ma	ay be treated as a unit for
4	Current value of plan's interest under this contract in the general account	at year end	. 4	
	Current value of plan's interest under this contract in separate accounts a	t year end	. 5	
6	Contracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
	If the carrier, service, or other organization incurred any specific costs in			
	the acquisition or retention of the contract or policy, enter amount		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group defen	red annuity		
	(3) other (specify)			
				_
f	If contract purchased, in whole or in part, to distribute benefits from a te	erminating plan, check here	>	
7	Contracts With Unallocated Funds (Do not include portions of these cor	tracts maintained in separate acc	ounts)	
а	Type of contract: (1) deposit administration (2)	immediate participation guarar	ntee	
	(3) guaranteed investment (4)	other >		
b	Balance at the end of the previous year		7b	
С	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account			
	(5) Other (specify below)	7c(5)		
	>			
_	(6) Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6))		7d	
е	2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			
	(1) Disbursed from fund to pay benefits or purchase annuities during year			
	(2) Administration charge made by carrier	7e(2)		
	(3) Transferred to separate account			
	(4) Other (specify below)	7e(4)		
	>			
			7./5	
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

	Irt III Welfare Benefit Contract Information If more than one contract covers the same group of emp employee organization(s), the information may be combin as a unit. Where contracts cover individual employees, the treated as a unit for purposes of this report.	ned for reporting pur	poses if such c	ontracts are	experience-rated
8	Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) b Dental e Temporary disability (accident and sickness) f X Long-terr i Stop loss (large deductible) j HMO con Other (specify)		Vision Supplemental PPO contract		d Life insurance hent l Prescription drug Indemnity contract
9	Experience-rated contracts:				
а	Premiums: (1) Amount received		491	L2454	
	(2) Increase (decrease) in amount due but unpaid			14755	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	-	-4107	
	(4) Earned ((1) + (2) - (3))			9a(4)	4371806
b	Benefit charges (1) Claims paid	9b(1)		31871	
	(2) Increase (decrease) in claim reserves	9b(2)	25,	76435	
	(3) Incurred claims (add (1) and (2))			9b(3)	5508306
	(4) Claims charged			9b(4)	
С	Remainder of premium: (1) Retention charges (on an accrual basis) -				
	(A) Commissions				
	(B) Administrative service or other fees	9c(1)(B)			
	(C) Other specific acquisition costs			3000	
	(D) Other expenses	9c(1)(D)		1662	
	(E) Taxes	9c(1)(E)		2732	
	(F) Charges for risks or other contingencies		52	24617	
	(G) Other retention charges	9c(1)(G)			
	(H) Total retention	<u></u>	<u>.</u>	9c(1)(H)	1332011
	(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 pr	rovide benefits after i	retirement	9d(1)	
	(2) Claim reserves			9d(2)	17696779
	(3) Other reserves			9d(3)	
	Dividends or retroactive rate refunds due. (Do not include amount en			9e	
10	Nonexperience-rated contracts:		,		
а	Total premiums or subscription charges paid to carrier			10a	
b	If the carrier, service, or other organization incurred any specific cos	sts in connection with	n		
	the acquisition or retention of the contract or policy, other than repo	orted in Part I, line 2			
	above, report amount			10b	
Sp	pecify nature of costs.				

Pa	art IV	Provision of Information			
11	Did the	insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No
12	If the a	nswer to line 11 is "Yes," specify the information not provided.			

Department of the Treasury Internal Revenue Service

Department of Labor

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.

OMB No. 1210-0110

2018

Pension Benefit Guara	,			are required to provide the ir ERISA section 103(a)(2).	nformatio	on		orm is Open to lic Inspection
For calendar plan year 20	118 or fiscal plan	year beginning 01/01	/201	8 and endir	ıg	12/31/	/2018	
A Name of plan INSURANCE A	ND BENE	FITS TRUST OF T	HE PE	ACE OFFICERS	1	ree-digit an number (PN)	501
INSURANCE A	ND BENE	on line 2a of Form 5500 FITS TRUST OF T				68-60	068469	
	t on a separate	cerning Insurance Con Schedule A. Individual contra						
(a) Name of insurance	e carrier	ANCE COMPANY						
	(c) NAIC	(d) Contract or	(e)	Approximate number of per	sons	Po	olicv or co	ntract year
(b) EIN	code	identification number		ed at end of policy or contra		(f) Fi		(g) To
93-0242990	69019	634126			97	01/01/	/2018	12/31/2018
in descending ord	er of the amou	· · · · · · · · · · · · · · · · · · ·	s and tota					d other persons
(a)	lotal amount o	f commissions paid	0	(b)	lotal am	ount of fees	s paid	0
3 Persons receiving		and fees. (Complete as many	entries as			fa.aa	_:-!	0
NONE	(a) Name a	nd address of the agent, brok	er, or ou	ier person to whom commis	510115 01	iees were p	raiu	
(b) Amount of sale	es and base		Fees	and other commissions pai	d			(e) Organization
commission	s paid	(c) Amount		(d) Purp	(d) Purpose			code
	(a) Name a	nd address of the agent, brok	er or oth	uer person to whom commis	sions or	fees were n	aid	-
	(a) Name a	The agent, blok	, or ou	S. PSISSITES WHO III SSITTING	<u> </u>	.000 WOIO P	-GIG	
(b) Amount of sale			Fees	and other commissions pai	d			(e) Organization
commission	o hain	(c) Amount		(d) Purp	ose			code
For Panerwork Redu	ction Act Noti	ce, see the Instructions for I	Form 550	00		Sc	chedule A	(Form 5500) 2018

Scnedule A (Form v. 171027

Schedule A (Form 5500) 2018	3	Page 2-	
(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 (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 (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 (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 Fees and other commissions paid (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 Fees and other commissions or fees were paid			
		<u> </u>	(e) Organization
	(c) Amount	(d) Purpose	code
(a) Name an	d address of the agent, bro	Dker, or other person to whom commissions or fees were paid	
	, , , , , , , , , , , , , , , , , , ,		
		Fees and other commissions paid	
Commissions paid	(c) Amount	(d) Purpose	code
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purnose	code

(d) Purpose

(c) Amount

Pa	art II Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of su purposes of this report.	ch individual contracts with each o	carrier ma	ay be treated as a unit for
4	Current value of plan's interest under this contract in the general account	at year end	. 4	
	Current value of plan's interest under this contract in separate accounts a	t year end	. 5	
6	Contracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
	If the carrier, service, or other organization incurred any specific costs in			
	the acquisition or retention of the contract or policy, enter amount		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group defen	red annuity		
	(3) other (specify)			
				_
f	If contract purchased, in whole or in part, to distribute benefits from a te	erminating plan, check here	>	
7	Contracts With Unallocated Funds (Do not include portions of these cor	tracts maintained in separate acc	ounts)	
а	Type of contract: (1) deposit administration (2)	immediate participation guarar	ntee	
	(3) guaranteed investment (4)	other >		
b	Balance at the end of the previous year		7b	
С	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account			
	(5) Other (specify below)	7c(5)		
	>			
_	(6) Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6))		7d	
е	2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			
	(1) Disbursed from fund to pay benefits or purchase annuities during year			
	(2) Administration charge made by carrier	7e(2)		
	(3) Transferred to separate account			
	(4) Other (specify below)	7e(4)		
	>			
			7./5	
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

_					
Pa	rt III Welfare Benefit Contract Information				
	If more than one contract covers the same group of empl employee organization(s), the information may be combin	,			
	as a unit. Where contracts cover individual employees, th		• •		•
	treated as a unit for purposes of this report.				,
<u> </u>					
0	Benefit and contract type (check all applicable boxes)		. □		4 □
	a Health (other than dental or vision) b Dental Congress f X Long-term		Vision		d Life insurance
	- H remporary disability (accident and sickness)		Supplementa RPO contract		. —
	Stop loss (large deductible) Other (specify)	ntract	K PPO contract	I	Indemnity contract
9	U Other (Specify)				
	Experience-rated contracts:	9a(1)		5348	
а	Premiums: (1) Amount received	- ::: +		29899	
	(2) Increase (decrease) in amount due but unpaid	0 - (0)		49099	
	(3) Increase (decrease) in unearned premium reserve			9a(4)	35247
b	(4) Earned ((1) + (2) - (3))	2. (.)		1000	33247
D	Benefit charges (1) Claims paid			-5240	
	(2) Increase (decrease) in claim reserves			9b(3)	-4240
	(3) Incurred claims (add (1) and (2))			9b(4)	-4240
_	(4) Claims charged			3D(1)	
·	Remainder of premium: (1) Retention charges (on an accrual basis)				
	(A) Commissions (B) Administrative service or other fees	2 2 2 2 2 2 2			
	(C) Other specific acquisition costs	0. (4)(0)			
		2 2 2 2 2 2 2 2 2		5654	
	(D) Other expenses (E) Taxes	0 (1)(=)		828	
	(F) Charges for risks or other contingencies			4230	
	(G) Other retention charges	2 (1)(2)		28775	
	(H) Total retention			9c(1)(H)	39487
	(2) Dividends or retroactive rate refunds. (These amounts were			9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to pro			9d(1)	21890
	(2) Claim reserves			9d(2)	
	(3) Other reserves			9d(3)	
е	Dividends or retroactive rate refunds due. (Do not include amount en			9e	
10	Nonexperience-rated contracts:		, , ,		
а	Total premiums or subscription charges paid to carrier			10a	
b	If the carrier, service, or other organization incurred any specific cost				
	the acquisition or retention of the contract or policy, other than report				
	above, report amount			10b	
Sp	pecify nature of costs.				

Pa	art IV	Provision of Information	_			
11	Did the	insurance company fail to provide any information necessary to complete Schedule A?	\prod	Yes	X	No
12	If the a	nswer to line 11 is "Yes," specify the information not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor

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.

OMB No. 1210-0110

2018

Pension Benefit Guara	,			are required to provide the ir ERISA section 103(a)(2).	nformatio	on		orm is Open to lic Inspection
For calendar plan year 20	118 or fiscal plan	year beginning 01/01	/201	8 and endir	ıg	12/31/	/2018	
A Name of plan INSURANCE A	ND BENE	FITS TRUST OF T	HE PE	ACE OFFICERS	1	ree-digit an number (PN)	501
INSURANCE A	ND BENE	on line 2a of Form 5500 FITS TRUST OF T				68-60	068469	
	t on a separate	cerning Insurance Con Schedule A. Individual contra						
(a) Name of insurance	e carrier	ANCE COMPANY						
	(c) NAIC	(d) Contract or	(e)	Approximate number of per	sons	Po	olicv or co	ntract year
(b) EIN	code	identification number		ed at end of policy or contra		(f) Fi		(g) To
93-0242990	69019	634126			97	01/01/	/2018	12/31/2018
in descending ord	er of the amou	· · · · · · · · · · · · · · · · · · ·	s and tota					d other persons
(a)	lotal amount o	f commissions paid	0	(b)	lotal am	ount of fees	s paid	0
3 Persons receiving		and fees. (Complete as many	entries as			fa.aa	_:-!	0
NONE	(a) Name a	nd address of the agent, brok	er, or ou	ier person to whom commis	510115 01	iees were p	raiu	
(b) Amount of sale	es and base		Fees	and other commissions pai	d			(e) Organization
commission	s paid	(c) Amount		(d) Purp	(d) Purpose			code
	(a) Name a	nd address of the agent, brok	er or oth	uer person to whom commis	sions or	fees were n	aid	-
	(a) Name a	The agent, blok	, or ou	S. PSISSITES WHO III SSITTING	<u> </u>	.000 WOIO P	-GIG	
(b) Amount of sale			Fees	and other commissions pai	d			(e) Organization
commission	o hain	(c) Amount		(d) Purp	ose			code
For Panerwork Redu	ction Act Noti	ce, see the Instructions for I	Form 550	00		Sc	chedule A	(Form 5500) 2018

Scnedule A (Form v. 171027

Schedule A (Form 5500) 2018	3	Page 2-		
(a) Name an	d address of the agent, bro	oker, 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	
	(c) Amount	(d) Purpose	code	
(a) Name an	d address of the agent, bro	Dker, 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	
Commissions paid	(c) Amount	(d) Purpose	code	
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base	Fees and other commissions paid		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purnose	code	

(d) Purpose

(c) Amount

Pa	art II Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of su purposes of this report.	ch individual contracts with each o	carrier ma	ay be treated as a unit for
4	Current value of plan's interest under this contract in the general account	at year end	. 4	
	Current value of plan's interest under this contract in separate accounts a	t year end	. 5	
6	Contracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
	If the carrier, service, or other organization incurred any specific costs in			
	the acquisition or retention of the contract or policy, enter amount		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group defen	red annuity		
	(3) other (specify)			
				_
f	If contract purchased, in whole or in part, to distribute benefits from a te	erminating plan, check here	>	
7	Contracts With Unallocated Funds (Do not include portions of these cor	tracts maintained in separate acc	ounts)	
а	Type of contract: (1) deposit administration (2)	immediate participation guarar	ntee	
	(3) guaranteed investment (4)	other >		
b	Balance at the end of the previous year		7b	
С	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account			
	(5) Other (specify below)	7c(5)		
	>			
_	(6) Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6))		7d	
е	2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			
	(1) Disbursed from fund to pay benefits or purchase annuities during year			
	(2) Administration charge made by carrier	7e(2)		
	(3) Transferred to separate account			
	(4) Other (specify below)	7e(4)		
	>			
			7./5	
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

Pa	Welfare Benefit Contract Information If more than one contract covers the same group of empl employee organization(s), the information may be combin as a unit. Where contracts cover individual employees, th treated as a unit for purposes of this report.	ned for reportin	g purposes if such	contracts are	experience-rated
8	Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) b Dental t Temporary disability (accident and sickness) stop loss (large deductible) Other (specify)	n disability ntract	c Vision g Supplementa PPO contrac	al unemployn	nent d
9	Experience-rated contracts:				
а	Premiums: (1) Amount received			3105	
	(2) Increase (decrease) in amount due but unpaid			16465	
	(3) Increase (decrease) in unearned premium reserve	9a(3)		_	
	(4) Earned ((1) + (2) - (3))			9a(4)	19570
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)	
С	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				
	(D) Other expenses			3409	
	(E) Taxes	9c(1)(E)		459	
	(F) Charges for risks or other contingencies			1370	
	(G) Other retention charges	9c(1)(G)		14332	
	(H) Total retention		· · · · · · · · · · · · · · · · · · ·	9c(1)(H)	19570
	(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 pro	ovide benefits	after retirement	9d(1)	
	(2) Claim reserves			9d(2)	4338
	(3) Other reserves			9d(3)	
е	Dividends or retroactive rate refunds due. (Do not include amount er			9e	
10	Nonexperience-rated contracts:				
а	Total premiums or subscription charges paid to carrier			10a	
b	If the carrier, service, or other organization incurred any specific cost				
	the acquisition or retention of the contract or policy, other than repo	rted in Part I, I	ne 2		
	above, report amount	,		10b	
Sr	pecify nature of costs.				
•					

Pa	rt IV Provision of Information		
11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No
12	If the answer to line 11 is "Yes," specify the information not provided. ▶		

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

Service Provider Information

► File as an attachment to Form 5500.

OMB No. 1210-0110

2018

This Form is Open to Public Inspection.

-or	r calendar plan y	ear 201	8 or fiscal plan y	ear beginning	0 T \ ()T/70T8	i a	and ending	9	12/31/2018	
	Name of plan	AND	BENEFITS	S TRUST (OF THE	PEACE	OFFICERS		В	Three-digit plan number (PN)	501
	Plan sponsor's					PORAC			D	Employer Identification	n Number (EIN)
P	art I Servic	e Pro	vider Inform	ation (see in	struction	าร)					
	indirectly, \$5,00 the person's pos	0 or mo	re in total compe th the plan durir	ensation (i.e., m ng the plan year	oney or any . If a persor	rthing else of received o i	monetary value) ir nly eligible indirect	n connecti t compens	ion v	person who received, with services rendered on for which the plan reting the remainder of	to the plan or eceived the
1	Information	on Pe	rsons Recei	ving Only El	igible Inc	lirect Con	npensation				
a	Check "Yes" or	"No" to	indicate whethe	r you are exclud	ding a perso	on from the re	emainder of this Pa			ney received only ons and conditions)	Yes X No
	•		•			•	on providing the re needed (see instru	•	sclos	sures for the service pr	oviders
		(b) Er	nter name and El	N or address of	person wh	o provided y	ou disclosures on	eligible inc	dire	ct compensation	
		(b) Fr	nter name and Fl	N or address of	nerson wh	o provided v	ou disclosures on	eligible inc	dired	ct compensation	
		(2) =									
		(b) Er	nter name and El	N or address of	person wh	o provided y	ou disclosures on	eligible inc	dire	ct compensation	
		(b) Er	nter name and El	N or address of	person wh	o provided y	ou disclosures on	eligible inc	dire	ct compensation	

Schedule C (Form 5500) 2018	Page 2 -
(b) Enter name and EIN or address of person who pro	ovided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who pro	ovided you disclosures on eligible indirect compensation
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(b) Enter name and EIN or address of person who pro	ovided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who pro	ovided you disclosures on eligible indirect compensation
	7
(b) Enter name and EIN or address of person who pro	ovided you disclosures on eligible indirect compensation
(b) Enter hame and Ent of address of person who pre	visual you discissed on singleto indirect compensation
(b) Entername and EIN an address of new trees.	wided you disclosures on clinible indirect
(b) Enter name and EIN or address of person who pro	ovided you disclosures on eligible indirect compensation

	Schedule C (Form 5	500) 2018			Page 3 -		
you a	nswered "Yes" to line	la on page 1, co noney or anythin	mplete as many entries	as needed to list each pe	empensation. Except for the erson receiving, directly or indicated to the plan or their position	ectly, \$5,000 or more	
	,	•	(a) Enter name and EIN	l or address (see instruct	tions)		
PORAC				23-7077256			
(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?	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	PARTY IN IN	TEREST 696172.	Yes No X	Yes No		Yes No	
	~			l or address (see instruct	tions)		
MYERS	-STEVENS TO	OHEY AND	CO. INC.	95-2637676			
(b) Service Code(s)	Relationship to employer, employer 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?	
15 50	NONE	472743.	Yes No X	Yes No		Yes No	
			_	_			
			(a) Enter name and EIN	or address (see instruct	tions)		
REICH	REICH ADELL & CVITAN 94-1205338						
(b)	(c)	(d)	(e)	(f)	(g)	(h)	

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none, enter -0	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	157029.	Yes No X	Yes No		Yes No

Page 3 -	
nsation.	Except for those persons for whom

	Schedule C (Form 5	500) 2018			Page 3 -	
						ept for those persons for whon
-			•	· ·		position with the plan during
	an year. (See instruction		g else of value, in conne	CHOIT WILLT SELVICES LETICE	red to the plan of their	position with the plan during
ti le pi	ari year. (See iristructio) i i 3 j .	(a) Enter name and EIN	N or address (see instruct	rions)	
שחב כ	EGAL COMPAN	v	(4) Enter hame and En	94-1050399	.10115)	
11111 0		•		J4 10303JJ		
(b)	(c)	(d)	(e)	(f)	_ (g)	(h)
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none, enter -0	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indire compensation receiv service provider exceligible indirect compensation for whanswered "Yes" to e	ved by luding a formula instead of an amount or estimated amount?
16	NONE	79184.	Yes No X	Yes No		Yes No
			(a) Enter name and EIN	N or address (see instruct	tions)	
LOS A	CENTURY PARI NGELES	CA	90067			
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indire compensation receive service provider exculpible indirec compensation for when swered "Yes" to early if none, enter	ved by luding t provider give you a formula instead of an amount or estimated amount?
27 51	NONE	48659.	Yes No X	Yes No	(9)	Yes No No
			(a) =			
VAVRI	NEK, TRINE,	DAY & CO) . , LLP	N or address (see instruct 95-2648289	ions)	
(b) Service Code(s)	Relationship to employer, employer, 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?	Enter total indirecompensation receives service provider excelligible indirecompensation for whanswered "Yes" to eee (f). If none, enter	ved by luding a formula instead of an amount or estimated amount?
10 50	NONE	32102.	Yes No X	Yes No		Yes No No

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Schedule C	/Farm	EEOO	2010
Scriedule C I		5500	1 ZU 10

	Schedule C (Form 5	500) 2018			Page 3 -	
you a	nswered "Yes" to line 1	la on page 1, co	mplete as many entries a	as needed to list each pe	erson receiving, directly or i	• • •
in tota	al compensation (i.e., m	noney or anything	g else of value) in conne	ction with services rende	red to the plan or their pos	sition with the plan during
the pl	an year. (See instructio	ons).				
			(a) Enter name and EIN	l or address (see instruct	tions)	
	T HALF					
	SAND HILL RO		0.400=			
MENLO	PARK	CA	94025			
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received I service provider excludir eligible indirect compensation for which y answered "Yes" to eleme (f). If none, enter -0	a formula instead of an amount or
61 50	NONE	16819.	Yes No	Yes No	0	• Yes No
	T FEINGLASS		(a) Enter name and EIN	or address (see instruct	tions)	
(In)	(2)	(-1)	(2)	L (6)	(1)	(1-)
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received I service provider excludir eligible indirect compensation for which y answered "Yes" to eleme (f). If none, enter -0	a formula instead of an amount or estimated amount?
29 50	NONE	12975.	Yes No X	Yes No		Yes No
			(a) Enter name and EIN	l or address (see instruct	tions)	
	N SOLUTIONS TH AVE, STE	2200 NY	10018			
(b) Service Code(s)	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 I service provider excludir eligible indirect compensation for which y answered "Yes" to eleme (f). If none, enter -0	a formula instead of an amount or estimated amount?
16 50	NONE	7881.	Yes No	Yes No	0	• Yes No

	Schedule C (Form 5	500) 2018			Page 3 -	
you ar in tota	mation on Other	Service Provila on page 1, connoney or anything	mplete as many entries a	as needed to list each pe	mpensation. Except for t rson receiving, directly or indirectly to the plan or their position	ectly, \$5,000 or more
trie pie	ari year. (See instruction) i i 3 j .	(a) Enter name and EIN	l or address (see instruct	ions)	
PHARM	ACY SOLUTION	NS	(=) Litter name and Litt	47-0866096	ions	
(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?
16 50	NONE	7208.	Yes No	Yes No	0.	Yes No
			(a) Enter name and EIN	l or address (see instruct	ions)	
(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)

Page	6	-
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_			 		
P		Termination Information on Acco	ountants and Enroll	led Actuaries (see in	structions)
		(complete as many entries as needed)			1 20 252222
		HEMMING MORSE, LLP			b EIN: 30-0702822
		AUDITOR			415 026 4000
a	Address:	177 DOLLER DOLD GUTTE	F 0 F		e Telephone: 415-836-4000
		177 BOVET ROAD, SUITE		0.4400	
		SAN MATEO	CA	94402	
_		THE EMPLOYEE BENEFIT PLAN AUDIT	DEDIDUMENT OF THE	EXICUING NUDIO EID	M MEDCED INDO A NEW EIDM
=X	planation:	THE EMPLOTEE BENEFIT PLAN AUDIT	DEPARIMENT OF THE	EXISTING AUDIT FIRE	M MERGED INIO A NEW FIRM
	Name:				b EIN:
	Position:				EIN.
<u>~</u>	Address:				A Tolonhano:
u	Address:				e Telephone:
=\/.	planation:				
-	piariatiori.				
	Name:				b EIN:
					B EIN:
	Position: Address:				A Talanhana.
u	Address:				e Telephone:
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— а	Name:				b EIN:
	Position:				- Liiv.
d	Address:				e Telephone:
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	Position:				LIIV.
d	Address:				e Telephone:
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_^	piai iatiUi I.				

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).

2018

OMB No. 1210-0110

► File as an attachment to Form 5500.

This Form is Open to Public Inspection

For calendar plan year 2018 or fiscal plan year be	ginning (01/0	1/2018	and	ending	12/	31/201	18
A Name of plan					В	Three-digit		
						plan numbe	er (PN)	501
INSURANCE AND BENEFITS TRUS	T OF	THE	PEACE	OFFICERS	R			
C Plan sponsor's name as shown on line 2a of Form	5500				D	Employer lo	dentification	n Number (EIN)
INSURANCE AND BENEFITS TRUS	T OF	THE	PORAC			68-60	68469	
Part I Asset and Liability Statement								

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
	Tel		4-	(a) Beginning of Year 617316	` '
		al noninterest-bearing cash	1a	01/310	301770
b		ceivables (less allowance for doubtful accounts):			
	(1)	Employer contributions	1b(1)	200407	100700
	(2)	Participant contributions	1b(2)	380407	190780
	(3)	Other SEE STATEMENT 1	1b(3)	1322812	1474754
С	Ge	neral investments:			
	(1)	Interest-bearing cash (incl. money market accounts & certificates of deposit) \dots	1c(1)	599	872
	(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)	3679865	4301919
(14)	Value of funds held in insurance co. general account (unallocated contracts)	1c(14)		
	15 <u>)</u>	Other SEE STATEMENT 2	1c(15)	751090	770928

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

Schedule H (Form 5500) 2018

v. 171027

		г		
1 d	Employer-related investments:		(a) Beginning of Year	(b) End of Year
	(1) Employer securities	1d(1)		
	(2) Employer real property			
е	Buildings and other property used in plan operation		24669	15319
f	Total assets (add all amounts in lines 1a through 1e)	1f	6776758	7716350
	Liabilities			
g	Benefit claims payable	1g	999000	517000
h	Operating payables	1h	221691	148073
i	Acquisition indebtedness	1i		
j	Other liabilities SEE STATEMENT 3	1j	1024601	1052739
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	2245292	1717812
	Net Assets			
ı	Net assets (subtract line 1k from line 1f)	11	4531466	5998538

Part II Income and Expense Statement

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
а	Contributions:			
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)		
	(B) Participants	2a(1)(B)	8085090	
	(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)		8085090
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)	16540	
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		16540
	(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)	182868	
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		182868
	(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)	-78735	
	(C) Total unrealized appreciation of assets.			
	Add lines 2b(5)(A) and (B)	2b(5)(C)		-78735

		_						
				(a) Am	ount		(b) Tota	al
	(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)					-4	24349
С	Other income SEE STATEMENT 4	2c					21	38333
d	Total income. Add all income amounts in column (b) and enter total Expenses	2d					99	19747
е	Benefit payment and payments to provide benefits:							
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		1	135374			
	(2) To insurance carriers for the provision of benefits				576557			
	(3) Other							
	(4) Total benefit payments. Add lines 2e(1) through (3)						67	11931
f	Corrective distributions (see instructions)				-		<u> </u>	
g	Certain deemed distributions of participant loans (see instructions)				-			
h					-			
ï	Interest expense (1) Professional fees				315550			
•					168915			
	(2) Contract administrator fees				48659			
	(3) Investment advisory and management fees(4) Other SEE STATEMENT 5				207620			
					207020		17	40744
	(5) Total administrative expenses. Add lines 2i(1) through (4)				-			52675
j	Total expenses. Add all expense amounts in column (b) and enter total Net Income and Reconciliation	<u>2j</u>					04	34073
l,		OI.					1 /	67072
k I	Net income (loss). Subtract line 2j from line 2d	2k			-		14	07072
•	Transfers of assets:	0(4)			-			
	(1) To this plan				-			
Dэ	rt III Accountant's Opinion	21(2)						
<u>. u</u>			t ll	4 - 41-11				
•	Complete lines 3a through 3c if the opinion of an independent qualified public	accountant is att	tached	to this	s Form 5500.			
_	Complete line 3d if an opinion is not attached.		\					
а	The attached opinion of all independent dualined public deceding in the time pr		tions):					
b	(1) X Unqualified (2) Qualified (3) Disclaimer (4)		0(00				T	X No
C	Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.10	03-8 and/or 103-1	2(a)?				Yes	X No
	Enter the name and EIN of the accountant (or accounting firm) below: (1) Name: EIDE BAILLY LLP			(O) [I	N: 45-02	2500	5.0	
А				2) EI	N: 43-04	2009	30	
a	The opinion of an independent qualified public accountant is not attached by		4.5			00.055	05004	04.50
Da	(1) This form is filed for a CCT, PSA, or MTIA. (2) It will be at Irt IV Compliance Questions	tached to the nex	Xt Form	5500	pursuant to	29 GFF	1 2520.11	J4-5U.
. a			- 1- 1	£ 1=	4la 4la 4ma /	l		
Г	CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not		a, 4e, 4	1, 49,	411, 4K, 4111, ²	in, or 5	•	
	103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete li	ne 41.	ſ	V	NI-			
_	During the plan year:			Yes	No	A	mount	
а	Was there a failure to transmit to the plan any participant contributions within							
	period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any pri	ior year						
	failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary				.			
L	Correction Program.)		4a		Х			
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				, l			
	5500) Part I if "Yes" is checked.)		4b		Х			

Page	4	-
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Schedule H (Form 5500) 2018

		_		Yes	No		Amount	
С	Were any leases to which the plan was a party in default or classified during the year	ear as						
	uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		4c		Х			
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.)		4d		Х			
е	Was this plan covered by a fidelity bond?		4e	Х			1000	000
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		Х			
g	Did the plan hold any assets whose current value was neither readily determinable							
	an established market nor set by an independent third party appraiser?		4g		Х			
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		Х			
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes							
	checked, and see instructions for format requirements.)		4i	Х				
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.)		4i		Х			
k	Were all the plan assets either distributed to participants or beneficiaries, transfern							
	to another plan, or brought under the control of the PBGC?		4k		Х			
- 1	Has the plan failed to provide any benefit when due under the plan?		41		Х			
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	d notice or						
	one of the exceptions to providing the notice applied under 29 CFR 2520.101-3		4n			_		
5 a	Has a resolution to terminate the plan been adopted during the plan year or any pr	rior plan year?			Yes	X No)	
	If "Yes," enter the amount of any plan assets that reverted to the employer this yea	ar		•		. –		
5 b	If, during this plan year, any assets or liabilities were transferred from this plan to a	nother plan(s),	ident	ify the	plan(s	s) to which	assets or lia	bilities
	were transferred. (See instructions.)							
	5b(1) Name of plan(s)	5	5b(2)	EIN(s)		5b(3) F	PN(s)
5 c	If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERIS	SA section 4021.))?	[]	Yes	No	☐ Not dete	ermined
	If "Yes" is checked, enter the My PAA confirmation number from the PBGC premiur	m filing for this	plan	year			(See ins	str.)

	00-000409
ES	STATEMENT 1
BEGINNING	ENDING
1322812.	1474754.
1322812.	1474754.
TMENTS	STATEMENT 2
BEGINNING	ENDING
751090.	770928.
751090.	770928.
TIES	STATEMENT 3
BEGINNING	ENDING
1024601.	1052739
1024601.	1052739.
	STATEMENT 4
	AMOUNT
	2138333
	2138333
EXPENSES	STATEMENT 5
	AMOUNT
	207620.
	BEGINNING 1322812. 1322812. TMENTS BEGINNING 751090. 751090. TIES BEGINNING 1024601. 1024601.