## Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor

## 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

OMB Nos. 1210-0110 1210-0089

2019

_	Administration the instructions to the Form 5500.							
Pensio	on Benefit Guaranty Corporation	1				orm is Open to Pเ Inspection	ublic	
Part I	Annual Report	Identification Information						
For cale	ndar plan year 2019 or t	fiscal plan year beginning 01/01/2019		and ending 12/31/20	)19			
A This	return/report is for:	a multiemployer plan		lloyer plan (Filers checking the mployer information in accored)			ns.)	
D		the first return/report	the final return	<i>'</i> ——				
<b>B</b> This i	return/report is:	an amended return/report		ear return/report (less than 12	2 months)			
C If the	plan is a collectively-ba	argained plan, check here						
<b>D</b> Chec	D Check box if filing under: Form 5558 automatic extension			the	DFVC program			
		special extension (enter description	)					
Part II	Basic Plan Info	ormation—enter all requested information	on					
1a Name of plan SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM					Three-digit plan number (PN) ▶	505		
						Effective date of pl	an	
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)					2b Employer Identification Number (EIN) 22-1500645			
SETON	HALL UNIVERSITY					2c Plan Sponsor's telephone number 973-761-9181		
	RANGE AVENUE DRANGE, NJ 07079-26	46				2d Business code (see instructions) 611000		
Caution	: A penalty for the late	or incomplete filing of this return/repo	rt will be assessed	unless reasonable cause is	s establisl	ned.		
		other penalties set forth in the instructions, swell as the electronic version of this return						
SIGN	Filed with authorized/va	alid electronic signature.	07/17/2020	TERRI DEMAREST				
HERE	Signature of plan ad	ministrator	Date	Enter name of individual s	igning as r	olan administrator		
SIGN HERE					<u> </u>			
IILIKE	Signature of employ	er/plan sponsor	Date	Enter name of individual s	igning as e	employer or plan sp	onsor	
SIGN								

Signature of DFE

Enter name of individual signing as DFE

Form 5500 (2019) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN **3c** Administrator's telephone number 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, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **4d** PN Sponsor's name Plan Name Total number of participants at the beginning of the plan year 1568 5 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). 1540 a(1) Total number of active participants at the beginning of the plan year ...... 6a(1) 1546 a(2) Total number of active participants at the end of the plan year ...... 6a(2)6b 15 Retired or separated participants receiving benefits..... 0 Other retired or separated participants entitled to future benefits...... 6c 1561 Subtotal. Add lines 6a(2), 6b, and 6c..... 6d Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total, Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item) ..... h Number of participants who terminated employment during the plan year with accrued benefits that were 6h less than 100% vested. Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)...... If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: **b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4B 4D 4E 4H 4L 4Q Plan funding arrangement (check all that apply) 9h Plan benefit arrangement (check all that apply) (1) Insurance (1) Insurance (2) (2) Code section 412(e)(3) insurance contracts Code section 412(e)(3) insurance contracts (3) Trust (3) Trust (4) General assets of the sponsor (4) General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

**b** General Schedules

X

(1) (2)

(3)

(4)

(5)

(6)

H (Financial Information)

3 A (Insurance Information)

I (Financial Information - Small Plan)

**G** (Financial Transaction Schedules)

C (Service Provider Information)D (DFE/Participating Plan Information)

a Pension Schedules

actuary

(1)

(2)

(3)

R (Retirement Plan Information)

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

11c Enter the Receipt Confirmation Code for the 2019 Form M-1 annual report. If the plan was not required to file the 2019 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.)

No

Receipt Confirmation Code\_\_\_\_\_

## **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

2019

	. ,		ERISA section 103(a)(2)		lion	This For	m is Open to Public Inspection
For calendar plan year 20	019 or fiscal pla	in year beginning 01/01/2019		and en	nding 12/31	1/2019	
A Name of plan SETON HALL UNIVERS	ITY WELFARE	BENEFIT PROGRAM			e-digit number (PN	l) <b>&gt;</b>	505
C Plan sponsor's name setton HALL UNIVERS	ITY			22-	1500645	ation Number	
		rning Insurance Contra A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca			(e) Approximate nu	umbor of	ı	Policy or o	ontract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	t end of	(f)	From	(g) To
06-0838648	70815	681147G	1546		01/01/2019	)	12/31/2019
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. Li	ist in line 3	the agents, I	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
41103 24265							
3 Persons receiving con	nmissions and f	fees. (Complete as many entrie	es as needed to report all	persons).			
		and address of the agent, broke	·	m commiss	ions or fees	were paid	
JAMES R NELLIGAN & A	SSOCIATES LI	BUILI	ROUTE 34 DING 4, SUITE 404A _, NJ 07719				
(b) Amount of sales a	ind base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code
	20233	10116	FEES				3
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
MERCER HEALTH AND E		2 4565	PAYSPHERE CIRCLE AGO, IL 60674			·	
(b) Amount of sales a	ind base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	20870						3

Page	2	_	1	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid MERCER HUMAN RESOURCE CONSULTING 4565 PAYSPHERE CIRCLE CHICAGO, IL 60674 Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code 7631 **BONUS** 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid 1800 ROUTE 34 BUILDING 4, SUITE 404A WALL, NJ 07719 JAMES R NELLIGAN & ASSOCIATES LLC Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code BONUS 6518 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	ets with each carrier may	/ be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		. 4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:				
U		State the basis of premium rates				
	а	State the basis of premium rates V				
	<b>L</b>				Ch	
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount.				
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
		(4)				
	_	Manager to contract the second		to a state to a second		
_	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ate participat	on guarantee		
		(3) guaranteed investment (4) other				
	L				76	
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
					7-(0)	
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			. 7d	0
	е	Deductions:	- 411			
		(1) Disbursed from fund to pay benefits or purchase annuities during year				
		(2) Administration charge made by carrier	.e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•	. ,			
		,				
		(5) Total deductions			. 7e(5)	0

**7**f

f Balance at the end of the current year (subtract line 7e(5) from line 7d)

P	art III	Welfare Benefit Contract Inform				
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual to the contract of the same than the contract covers the same the information of the contract covers the covers	ting purposes if s	uch contracts are expe	erience-rated as a unit. Where o	ontracts cover individual
8	Benefit a	and contract type (check all applicable boxes)	)			
	а∏н	lealth (other than dental or vision)	<b>b</b> Dental	с∏	Vision	<b>d</b> X Life insurance
	е ⊟⊤	emporary disability (accident and sickness)	f X Long-term	n disability <b>g</b> 🗌	Supplemental unemployment	h Prescription drug
		Stop loss (large deductible)	j HMO con	·	PPO contract	I  Indemnity contract
		Other (specify) ACCIDENTAL DEATH AND		_	T T O COMMON	
		Silici (oposity) Theorem 14 The Bertin Me	DIOMEMBERME			
9	Experier	nce-rated contracts:				
_		miums: (1) Amount received		9a(1)		
		Increase (decrease) in amount due but unpai				_
	` '	Increase (decrease) in unearned premium re				
		Earned ((1) + (2) - (3))			9a(4)	C
	<b>b</b> Be	nefit charges (1) Claims paid		9b(1)		
	(2)	Increase (decrease) in claim reserves		9b(2)		
	(3)	Incurred claims (add (1) and (2))				C
	(4)	Claims charged			9b(4)	
	<b>C</b> Re	mainder of premium: (1) Retention charges (	on an accrual bas	is)		
		(A) Commissions		9c(1)(A)		
		(B) Administrative service or other fees				
		(C) Other specific acquisition costs				
		(D) Other expenses		0-(4)(5)		
		(E) Taxes				_
		(F) Charges for risks or other contingencies.		0 (4)(0)		
		(G) Other retention charges			00/4)/11	D (
	(0)	(H) Total retention	_	_		)
		Dividends or retroactive rate refunds. (These	<u> </u>	_ ·		
		atus of policyholder reserves at end of year: (	•	•		
		Claim reserves				
	` '	Other reserves vidends or retroactive rate refunds due. (Do r				
10		perience-rated contracts:	ot include amoun	it entered in line 30(2).	., <del>3e</del>	
		tal premiums or subscription charges paid to	rarrier		10a	619723
						013720
	ret	he carrier, service, or other organization incur ention of the contract or policy, other than rep nature of costs	, ,		•	
		ention of the contract or policy, other than repnature of costs.	orted in Part I, lin	e 2 above, report amo	unt 10b	
	art IV	Provision of Information e insurance company fail to provide any inform	nation necessary	to complete Schedule	A? \( \text{Yes} \)	X No
					A:	
12	If the a	answer to line 11 is "Yes," specify the informa	ion not provided.	•		

## **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2019

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 20	19 or fiscal pla	an year beginning 01/01/2019	an	d ending 12/3	31/2019		
A Name of plan SETON HALL UNIVERSI	TY WELFARE	BENEFIT PROGRAM		Three-digit plan number (P	PN) •	505	
C Plan sponsor's name as shown on line 2a of Form 5500 SETON HALL UNIVERSITY  D Employer Identification Number (EIN) 22-1500645					(EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca		E COMPANY AND AFFILIATES					
	(c) NAIC	(d) Contract or	(e) Approximate number (		Policy or co	ontract year	
(b) EIN	code	identification number	persons covered at end o policy or contract year	f (f)	) From	<b>(g)</b> To	
59-1031071	67369	3334085	1158	01/01/201	19	12/31/2019	
2 Insurance fee and com descending order of the		nation. Enter the total fees and tota	commissions paid. List in lir	ne 3 the agents	, brokers, and o	ther persons in	
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid						
10576 161414							
3 Persons receiving com	missions and	fees. (Complete as many entries a	as needed to report all person	s).			
	(a) Name	and address of the agent, broker, o	or other person to whom comi	missions or fee	s were paid		
MERCER HEALTH AND B	ENEFITS, LLO		YSPHERE CIRCLE O, IL 60674				
(b) Amount of sales ar	nd base	Fees	and other commissions paid				
commissions pa		(c) Amount	<b>(d)</b> Pur			(e) Organization code	
	10576	157766 BEI	NEFIT ADVISOR PAYMENTS	6		3	
	(a) Name	and address of the agent, broker, o	or other person to whom com	missions or fee	s were paid		
MERCER HEALTH AND B		C 4565 PA	YSPHERE CIRCLE O, IL 60674		,		
(h) Amount of sales ar	(b) Amount of sales and base Fees and other commissions paid						
commissions pa		(c) Amount	<b>(d)</b> Pur	pose		(e) Organization code	
		3648 SE	RVICE/GENERAL AGENT PA	AYMENTS		3	
	A 1 N 1				<u> </u>		

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
		Fees and other commissions paid	<b>(e)</b> Organization		
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount (d) Purpose				
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
commodene para			0000		
(a) Nar	ne and address of the agent, broker	r, 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		(e) Organization		
commissions paid	(4)	(-)	code		
(a) Nar	ne and address of the agent broker	r, or other person to whom commissions or fees were paid			
( <b>a)</b> (vai	ne and address of the agent, broker	, of dutel person to whom commissions of rees were paid			
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid  (d) Purpose	<b>(e)</b> Organization		
commissions paid	(c) Amount	(a) i dipose	code		
(a) Nor	no and address of the agent broker	or other person to whom commissions or face were paid			
(a) Nai	ne 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	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	ets with each carrier may	/ be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		. 4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:				
U		State the basis of premium rates				
	а	State the basis of premium rates V				
	<b>L</b>				Ch	
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount.				
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
		(4)				
	_	Manager to contract the second		to a state to a second		
_	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ate participat	on guarantee		
		(3) guaranteed investment (4) other				
	L				76	
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
					7-(0)	
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			. 7d	0
	е	Deductions:	- 411			
		(1) Disbursed from fund to pay benefits or purchase annuities during year				
		(2) Administration charge made by carrier	.e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•	. ,			
		,				
		(5) Total deductions			. 7e(5)	0

**7**f

f Balance at the end of the current year (subtract line 7e(5) from line 7d)

Р	art	111	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual to the contract of	group of employees of the ting purposes if such conti	racts are expe	erience-rated as a unit	. Where c	ontracts cover	
8	Ben	efit a	nd contract type (check all applicable boxes)						
	а	X He	ealth (other than dental or vision)	<b>b</b> X Dental	c 🗌	Vision		<b>d</b> Life ins	urance
	е	Te	emporary disability (accident and sickness)	f Long-term disabilit	ty $\mathbf{g}$	Supplemental unemp	oloyment	h Prescri	ption drug
	i	=	op loss (large deductible)	j	· — —	PPO contract		I X Indemn	_
	m	_	ther (specify)	,	Ш			- <u>-</u>	.,
	!		(5)						
9	Ехр	eriend	ce-rated contracts:						
	a	Prem	iums: (1) Amount received		9a(1)				
		(2) lı	ncrease (decrease) in amount due but unpai	d	9a(2)				
		(3) lı	ncrease (decrease) in unearned premium res	serve	9a(3)				
		(4) E	Earned ((1) + (2) - (3))				9a(4)		C
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) lı	ncrease (decrease) in claim reserves		9b(2)				
		(3) lı	ncurred claims (add (1) and (2))				9b(3)		C
		(4) C	Claims charged				9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (	n an accrual basis)					
			(A) Commissions						
			(B) Administrative service or other fees						
			(C) Other specific acquisition costs						
			(D) Other expenses		0-/4\/5\				
			(E) Taxes						
			(F) Charges for risks or other contingencies.						
			(G) Other retention charges				00/11/1	\ \ \	
			(H) Total retention	_			9c(1)(H	,	
			Dividends or retroactive rate refunds. (These		لسنا				
	d		tus of policyholder reserves at end of year: (1						
		` '	Claim reserves				9d(2)		
	е	` '	Other reservesdends or retroactive rate refunds due. (Do n				9d(3) 9e		
10			perience-rated contracts:	of include amount entered	i iii iiiie 30(2).	)	36		
	a		al premiums or subscription charges paid to	rarrier			10a		18237875
							100		10257073
	<b>b</b> Spe	rete	e carrier, service, or other organization incur ntion of the contract or policy, other than rep nature of costs.				10b		
n		ecify r	nature of costs.	orted in Part I, line 2 abov	e, report amo	unt	10b		
Р	art	IV	Provision of Information			<del>-</del>			
11	Die	d the	insurance company fail to provide any inforn	nation necessary to compl	ete Schedule	A?	Yes	X No	
12	lf t	he ar	nswer to line 11 is "Yes," specify the informat	ion not provided.					

## SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2019

This Form is Open to Public Inspection

		p 4.10 444.11.11				inspection
For calendar plan year 20	19 or fiscal pla	in year beginning 01/01/2019		and er	nding 12/31/2019	
A Name of plan SETON HALL UNIVERSI	TY WELFARE	BENEFIT PROGRAM		B Thre	ee-digit n number (PN)	505
C Plan sponsor's name a SETON HALL UNIVERSIT	TY			22-	oyer Identification Number 1500645	
		rning Insurance Contract  A. Individual contracts grouped				
Coverage Information:	ato coricadio 7	t. marriada contracto groupea	as a driik iii i arts ii arta ii	i can be re	ported on a single cone.	Jaio 71.
(a) Name of insurance ca		COMPANY				
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year
(b) EIN	code	identification number	persons covered at policy or contract		(f) From	<b>(g)</b> To
43-0949844	71870	1008322	2607		01/01/2019	12/31/2019
descending order of the	amount paid. amount of com	nation. Enter the total fees and to nmissions paid fees. (Complete as many entrie and address of the agent, broke	es as needed to report all	(b) To	otal amount of fees paid	d other persons in
(b) Amount of sales ar	nd base		ees and other commissior			
commissions paid		(c) Amount		(d) Purpos	e	(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to whor	n commiss	sions or fees were paid	
(b) Amount of sales ar	nd base	F	ees and other commissior	ns paid		
commissions pa		(c) Amount	(	d) Purpos	e	(e) Organization code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
		Fees and other commissions paid	<b>(e)</b> Organization		
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount (d) Purpose				
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
commodene para			0000		
(a) Nar	ne and address of the agent, broker	r, 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		(e) Organization		
commissions paid	(4)	(-)	code		
(a) Nar	ne and address of the agent broker	r, or other person to whom commissions or fees were paid			
( <b>a)</b> (vai	ne and address of the agent, broker	, of dutel person to whom commissions of rees were paid			
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid  (d) Purpose	<b>(e)</b> Organization		
commissions paid	(c) Amount	(a) i dipose	code		
(a) Nor	no and address of the agent broker	or other person to whom commissions or face were paid			
(a) Nai	ne 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	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	ets with each carrier may	/ be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		. 4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:				
U		State the basis of premium rates				
	а	State the basis of premium rates V				
	<b>L</b>				Ch	
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in co			6d	
		retention of the contract or policy, enter amount.				
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
		(4)				
	_	Manager to continue to the large transfer and the Patrikesta have the force of the second		to a state to a second		
_	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ate participat	on guarantee		
		(3) guaranteed investment (4) other				
	L				76	
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
					7-(0)	
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			. 7d	0
	е	Deductions:	- 411			
		(1) Disbursed from fund to pay benefits or purchase annuities during year				
		(2) Administration charge made by carrier	.e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•	. ,			
		,				
		(5) Total deductions			. 7e(5)	0

**7**f

f Balance at the end of the current year (subtract line 7e(5) from line 7d)

Р	art	III Welfare Benefit Contract Informa	tion				
		If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	ng purposes if such contr	acts are expe	erience-rated as a uni	t. Where co	ontracts cover individual
R	Ren	nefit and contract type (check all applicable boxes)					
Ü	F		<b>b</b> Dental	c 🔽	Vision		<b>d</b> ☐ Life insurance
	a		_				
	е	Temporary disability (accident and sickness)	f Long-term disabilit	у <b>g</b> <u></u>	Supplemental unem	ployment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Exp	erience-rated contracts:	r				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium rese	-	9a(3)		- (1)	
		(4) Earned ((1) + (2) - (3))				. 9a(4)	C
	b	Benefit charges (1) Claims paid		9b(1)			_
		(2) Increase (decrease) in claim reserves	L.			01 (0)	
		(3) Incurred claims (add (1) and (2))				9b(3)	0
	_	(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on	· ·	00(1)(A)			_
		(A) Commissions(B) Administrative service or other fees		9c(1)(A) 9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			_
		(E) Taxes					
		(F) Charges for risks or other contingencies		9c(1)(F)			_
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	C
		(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)	_			. 9d(1)	
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves					
(3) Other reserves							
10 Nonexperience-rated contracts:							
	а	Total premiums or subscription charges paid to ca	ırrier			. 10a	141681
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount							
	Spe	ecify nature of costs.	,	-, -,		l.	
_	0=1	IV Provision of Information					
	art				П		
		d the insurance company fail to provide any informa		ete Schedule	A?	Yes	X No
12	l If t	the answer to line 11 is "Yes," specify the information	n not provided.				

### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Reposit Guaranty Corr

# 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

2019

This Form is Open to Bublio

1 6113	on benefit dualanty corporation				Inspection	ublic	
Part		Identification Information					
For cale	endar plan year 2019 or fi	scal plan year beginning 01/01			/31/2019		
A This	This return/report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)					ons.)	
		X a single-employer plan	a DFE (specify	)			
B This	return/report is:	the first return/report	return/report the final return/report				
		an amended return/report	a short plan ye	12 months)			
C If the	e plan is a collectively-bar	gained plan, check here					
D Che	ck box if filing under:	Form 5558	automatic exter	sion	the DFVC program		
		special extension (enter descript	tion)		ш . ж		
Part I	I Basic Plan Info	rmation—enter all requested inform	nation				
	me of plan TON HALL UNIVER	<b>1b</b> Three-digit plan number (PN) ▶	505				
					1c Effective date of pl 09/16/1966	lan	
Mai	n sponsor's name (emplo iling address (include roor or town, state or province	2b Employer Identification Number (EIN) 22-1500645					
SE	TON HALL UNIVER	2c Plan Sponsor's telephone number 973-761-9181					
400 S ORANGE AVENUE					2d Business code (see instructions) 611000		
50	UTH ORANGE	NJ 07079-2646					
Caution	: A penalty for the late of	or incomplete filing of this return/re	port will be assessed u	inless reasonable cause	e is established.		
Under p	enalties of perjury and oth	ner penalties set forth in the instruction well as the electronic version of this re	ns. I declare that I have	examined this return/repor	t including accompanying sche	edules, nplete.	
SIGN	Terri L	Demarest	07/17/2020	Terri De	marest		
	Signature of plan adm	inistrator	Date	Enter name of individual	l signing as plan administrator		
SIGN	Terri D	emarest	07/17/2020	Torsi )	erri Demarest		
	Signature of employer	/plan sponsor	Date	Enter name of individual	signing as employer or plan sp	onsor	
SIGN HERE							
For Don	Signature of DFE	lotice, see the Instructions for Forn	Date	Enter name of individual			
. or rap	GINOIK LEGINGROU ACT N	louce, see the instructions for Forn	1 5500.		Form 5500	(2019)	

	Form 5	500 (2019)	Page 2				
3a				3b Administrator's EIN			
					3c Administr	rator's telephone	
					number		
4	If the name a	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,				4b EIN	
а	enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: Sponsor's name				4d PN		
C	Plan Name						
5		of participants at the beginning of the plan year			5	1,568	
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 num	ber of active participants at the beginning of the plan year			6a(1)	1,540	
		ber of active participants at the end of the plan year			6a(2)	1,546	
					6b	15	
b		parated participants receiving benefits					
C	Other retired or separated participants entitled to future benefits				6c		
d	Subtotal. Add lines 6a(2), 6b, and 6c.					1,561	
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.						
f	Total. Add lines 6d and 6e.						
g		articipants with account balances as of the end of the plan year			6-		
		is item)			6g		
h		articipants who terminated employment during the plan year with			6h		
7	Enter the total	al number of employers obligated to contribute to the plan (only	multiemployer plans comp	elete this item)	7		
8a	If the plan pr	ovides pension benefits, enter the applicable pension feature co	des from the List of Plan	Characteristics Code	s in the instru	ictions:	
L	16 th 1	wide walkers have like a should be applied by a supplied by a factor and	loo from the List of Blan C	haractaristics Cadas	in the instruc	tione:	
D	4A 4B	ovides welfare benefits, enter the applicable welfare feature code $4 ext{D}$ $4 ext{E}$ $4 ext{H}$ $4 ext{L}$ $4 ext{Q}$	les from the List of Flam C	naracienstics codes	in the monde	dons.	
Qa	Dlan funding	arrangement (check all that apply)	9b Plan benefit arrang	ement (check all tha	at apply)		
Ju	(1)	Insurance		ırance			
	(2)	Code section 412(e)(3) insurance contracts	(2) Cod	le section 412(e)(3) i	insurance con	tracts	
	(3)	Trust	(3) Trus				
	(4) X	General assets of the sponsor		eral assets of the sp	PENALTHONE		
10	Check all ap	plicable boxes in 10a and 10b to indicate which schedules are a	ttached, and, where indic	ated, enter the numb	er attached.	(See instructions)	
â	Pension Schedules b General Schedules						
	(1)	R (Retirement Plan Information)	(1)	H (Financial Inform	nation)		
	(2) []	MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Inform	nation – Small	Plan)	
	(2)	Purchase Plan Actuarial Information) - signed by the plan	(3) X <u>3</u>	A (Insurance Infor	mation)		
		actuary	(4)	C (Service Provide	er Information	)	
	(3)	SB (Single-Employer Defined Benefit Plan Actuarial	(5)	D (DFE/Participati	ng Plan Inforr	nation)	
	( <b>v</b> )	Information) - signed by the plan actuary	(6)	G (Financial Trans	saction Sched	ules)	