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

2023

This Form is Open to Public Inspection

Part I	Annual Report	Identification Information					
For cale	ndar plan year 2023 or fis	scal plan year beginning 01/01/2023		and ending 12/31/2023			
A This	eturn/report is for:	a multiemployer plan		oloyer plan (Filers checking this b mation in accordance with the fo			iting
		x a single-employer plan	a DFE (specify	·)		,	
B This i	eturn/report is:	the first return/report	the final return	/report			
		an amended return/report	a short plan ye	ear return/report (less than 12 mo	onths)		
C If the	plan is a collectively-bar	gained plan, check here					
D Chec	k box if filing under:	X Form 5558	automatic exte	nsion	☐ the	e DFVC program	
		special extension (enter description	n)				
E If this	is a retroactively adopte	d plan permitted by SECURE Act section	201, check here)			
Part II	Basic Plan Info	rmation—enter all requested informatio	n				
	ne of plan I HALL UNIVERSITY WE	ELFARE BENEFIT PROGRAM			1b	Three-digit plan number (PN) ▶	505
					1c	Effective date of plants o	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		
	PRANGE AVENUE ORANGE, NJ 07079264	46			2d	Business code (see instructions) 611000	Э
Caution	: A penalty for the late	or incomplete filing of this return/repor	t will be assessed (unless reasonable cause is es	tablis	hed.	
Under pe statemer	enalties of perjury and otlents and attachments, as well as signed by:	her penalties set forth in the instructions, I well as the electronic version of this return	declare that I have of heport, and to the be	examined this return/report, incluest of my knowledge and belief,	uding it is tr	accompanying sche ue, correct, and com	dules, nplete.
SIGN	Gerri Demarest C7BA625D741C4C6		10/8/2024	Terri Demarest			
				Enter name of individual signing as plan administrator			
SIGN							

Date

Date

Signature of employer/plan sponsor

Signature of DFE

HERE

SIGN HERE Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

	Form 5500 (2023)	Page 2						
3a	Plan administrator's name and address X Same as Plan Sponsor			3b Administra	tor's EIN			
				3c Administra number	tor's telephone			
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin enter the plan sponsor's name, EIN, the plan name and the plan number from			4b EIN				
a c	Sponsor's name Plan Name		•	4d PN				
5	Total number of participants at the beginning of the plan year			5	1500			
6	Number of participants as of the end of the plan year unless otherwise stated	(welfare plan	ns complete only lines 6a(1),	3				
	6a(2), 6b, 6c, and 6d).							
a	1) Total number of active participants at the beginning of the plan year			6a(1)	1489			
a	2) Total number of active participants at the end of the plan year			6a(2)	1471			
b	Retired or separated participants receiving benefits			6b	11			
С	Other retired or separated participants entitled to future benefits			6c	0			
d	Subtotal. Add lines 6a(2), 6b, and 6c.			6d	1482			
е	Deceased participants whose beneficiaries are receiving or are entitled to	receive bene	fits	6e				
f	Total. Add lines 6d and 6e .			6f				
g	complete this terry.			6g(1)				
g	complete this item)			6g(2)				
_h	Number of participants who terminated employment during the plan year v less than 100% vested			6h				
7	Enter the total number of employers obligated to contribute to the plan (only n			7				
b	If the plan provides pension benefits, enter the applicable pension feature code If the plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E 4H 4L 4Q	es from the Li	st of Plan Characteristics Codes	s in the instructio				
9a	Plan funding arrangement (check all that apply) (1)	(1)	enefit arrangement (check all tha	at apply)				
	(2) Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3)	insurance contra	acts			
	(3) Trust	(3)	Trust					
	(4) X General assets of the sponsor	(4)	X General assets of the sp	onsor				
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at	, ,	,	per attached. (Se	ee instructions)			
а	Pension Schedules		al Schedules					
	(1) R (Retirement Plan Information)	(1)	H (Financial Information					
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(2) (3)	I (Financial InformationX A (Insurance Information	,	ached ⁷			
	actuary	(4)	C (Service Provider Info					
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5)	D (DFE/Participating Pla					
	(4) DCG (Individual Plan Information) – Number Attached	(6)	G (Financial Transaction	n Schedules)				
	(5) MEP (Multiple-Employer Retirement Plan Information)	, ,	<u> </u>	,				

Receipt Confirmation Code_

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

Pension Benefit Guaranty Co		▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				Inspection		
For calendar plan year 20	23 or fiscal pla	n year beginning 01/01/2023		and en	ding 12/3	31/2023	,	
A Name of plan SETON HALL UNIVERS	TY WELFARE	BENEFIT PROGRAM			e-digit number (P i	N) •	505	
C Plan sponsor's name a SETON HALL UNIVERSI	C Plan sponsor's name as shown on line 2a of Form 5500				-	ation Number (EIN)	
22-1500645								
		rning Insurance Contra A. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca								
(b) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f)	From	(g) To	
06-0838648 70815		ADDS08874	1471		01/01/202	3	12/31/2023	
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid					of fees paid			
		51						
3 Persons receiving com		ees. (Complete as many entrie						
MERCER HEALTH AND E			AVENUE OF THE AMER		ions or fees	were paid		
			FLOOR YORK, NY 10036					
		F	ees and other commission	ne naid				
(b) Amount of sales a commissions pa	I	(c) Amount		ees and other commissions paid (d) Purpose			(e) Organization code	
	51						3	
	(a) Name	and address of the agent broke	or other person to when		iono or food	were poid		
	(a) Name a	and address of the agent, broke	er, or other person to who	III COMINISS	ions or iees	were paid		
(b) Amount of sales a	nd base	F	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
]	

Schedule A (Form 5500) 2	2023	Page 2 –	
	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	<u> </u>		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	me 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	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
,	,		
(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
•	-		
			1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me 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	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	•		

Pa	art	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	ridual contra	cts with each carrier may	be treated	l as a unit for purposes of
4 C	Curr	ent value of plan's interest under this contract in the general account at year		4		
5 C	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6 C	Cont	racts With Allocated Funds:				
á	а	State the basis of premium rates •				
ı	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 coretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
•	Э	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7 C	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in	separate accounts)		
ć	а	Type of contract: (1) deposit administration (2) immedia (3) guaranteed investment (4) other		tion guarantee		
ı	b	Balance at the end of the previous year			7b	
-	C	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	- (0)			
		(3) Interest credited during the year	- (-)			
		(4) Transferred from separate account	= (4)			
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	- (2)			
		(4) Other (specify below)	- (1)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

D:	art III	Welfare Benefit Contract Informa	ation						
	A. C III	If more than one contract covers the same	group of employees of th			, , ,		, , ,	(//
		the information may be combined for repor- employees, the entire group of such individ							ıdividual
0	D64			arrier maj	, 50	treated as a drift for pt	11 poses of 1	ins report.	
	_	nd contract type (check all applicable boxes)	. —		٦.	1 . /:-:		d 🔽 ı :£- :	
	=	ealth (other than dental or vision)	b Dental		_	Vision		d X Life insu	
	e ∐ Te	mporary disability (accident and sickness)	f Long-term disabili	-	_ =	Supplemental unemp	oloyment	h Prescrip	tion drug
	ш	op loss (large deductible)	j HMO contract		k _	PPO contract		I Indemnit	y contract
	m X Ot	her (specify) ▶ ACCIDENTAL DEATH AND	DISMEMBERMENT						
	_								
9 E	Experienc	ce-rated contracts:							
	a Prem	iums: (1) Amount received		9a(1))				
	(2) Ir	ncrease (decrease) in amount due but unpai	i	9a(2))				
	(3) Ir	ncrease (decrease) in unearned premium res	erve	9a(3))		1		
	(4) E	arned ((1) + (2) - (3))					9a(4)		
	b Ben	efit charges (1) Claims paid		9b(1					
	` '	ncrease (decrease) in claim reserves							
		ncurred claims (add (1) and (2))					9b(3)		
	` '	claims charged					9b(4)		
		nainder of premium: (1) Retention charges (c		0-/4\/	A \			_	
		(A) Commissions		9c(1)(_	
		(B) Administrative service or other fees (C) Other specific acquisition costs		9c(1)(
		(D) Other expenses		9c(1)(l	_			_	
		(E) Taxes		9c(1)(l	_				
		(F) Charges for risks or other contingencies.		9c(1)(I					
		(G) Other retention charges		9c(1)(
		(H) Total retention					9c(1)(H)	
		Oividends or retroactive rate refunds. (These	_		_		9c(2)		
		us of policyholder reserves at end of year: (1	_		_		9d(1)		
		Claim reserves	•				9d(2)		
	. ,	Other reserves					9d(3)		
	e Divid	dends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9	c(2)	.)	9e		
10	Nonexp	erience-rated contracts:							
	a Tota	al premiums or subscription charges paid to o	arrier				10a		1012
	b If the	e carrier, service, or other organization incur	red any specific costs in o	onnection	n wit	h the acquisition or			
		ntion of the contract or policy, other than rep	orted in Part I, line 2 abov	e, report	amo	ount	10b		
	Specify n	ature of costs.							
Da	art IV	Provision of Information							
				1.4. 2 :		40	Voc	Пис	
		insurance company fail to provide any inform		iete Sche	dule	A?X	Yes	No	
12	If the ar	swer to line 11 is "Yes," specify the informat	on not provided. 🕨						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

Pension Benefit Guaranty Co	rporation	▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				This Form is Open to Public Inspection		
For calendar plan year 202	23 or fiscal plaı	n year beginning 01/01/2023		and en	ding 12/3	31/2023		
A Name of plan SETON HALL UNIVERSI	TY WELFARE	BENEFIT PROGRAM	B Three-digit plan number (PN)			N) •	505	
C Plan sponsor's name a SETON HALL UNIVERSI	e 2a of Form 5500		· ·	yer Identific 1500645	ation Number	(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		COMPANY AND AFFILIATES	(a) Aiii			Dellawara		
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate not persons covered a policy or contract	it end of	(f)	From	(g) To	
59-1031071 67369		3334085	1025		01/01/202	3	12/31/2023	
2 Insurance fee and coming descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and o	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
							209824	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid		
MERCER HEALTH AND B	ENEFITS, LLC		PAYSPHERE CIRCLE AGO, IL 60674				-	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid				
commissions pai		(c) Amount	ENEET ADVICED DAY	(d) Purpos	е		(e) Organization code	
209824 BENEFIT ADVISOR PAYMENTS						3		
	(a) Name a	and address of the agent, broker	or other person to who	m commiss	ions or fees	were naid		
	(a) Name e	ina address of the agent, broker	, or other person to who		10110 01 1000	were paid		
(b) Amount of color or	nd base	Fe	es and other commission	ns paid				
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpose			(e) Organization code	

Schedule A (Form 5500) 2	2023	Page 2 –	
	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	<u> </u>		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	me 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	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
,	,		
(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
•	-		
			1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me 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	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	•		

Pa	art	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	ridual contra	cts with each carrier may	be treated	l as a unit for purposes of
4 C	Curr	ent value of plan's interest under this contract in the general account at year		4		
5 C	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6 C	Cont	racts With Allocated Funds:				
á	а	State the basis of premium rates •				
ı	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 corretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
•	Э	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7 C	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in	separate accounts)		
ć	а	Type of contract: (1) deposit administration (2) immedia (3) guaranteed investment (4) other		tion guarantee		
ı	b	Balance at the end of the previous year			7b	
-	C	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	- (0)			
		(3) Interest credited during the year	- (-)			
		(4) Transferred from separate account	= (4)			
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	- (2)			
		(4) Other (specify below)	- (1)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

F	art I	II Welfare Benefit Contract Information If more than one contract covers the same group of employe the information may be combined for reporting purposes if se employees, the entire group of such individual contracts with	uch contracts ar	e exp	perience-rated as a un	it. Where co	ontract	s cover individual
8	Bene	efit and contract type (check all applicable boxes)						
	a 🗴	Health (other than dental or vision) b Dental		С	Vision		d□	Life insurance
	еĒ		n disability	g	∃ Supplemental unen	nolovment	=	Prescription drug
	: [-	e k □	PPO contract	pioymone	- =	
	' <u> </u>	Stop loss (large deductible) j HMO conf	ıracı	r.	_ PPO contract		•	Indemnity contract
	m	Other (specify)						
							1	
9	Expe	rience-rated contracts:			T		_	
	a F	Premiums: (1) Amount received					_	
		(2) Increase (decrease) in amount due but unpaid					_	
		(3) Increase (decrease) in unearned premium reserve				T		
		(4) Earned ((1) + (2) - (3))			 T	9a(4)		
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves	9b(2	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 bas	is)					
		(A) Commissions	9c(1)	(A)				
		(B) Administrative service or other fees	9c(1)	(B)				
		(C) Other specific acquisition costs	9c(1)	(C)				
		(D) Other expenses	9c(1)	(D)				
		(E) Taxes	9c(1)	(E)				
		(F) Charges for risks or other contingencies	9c(1)	(F)				
		(G) Other retention charges	9c(1)	(G)				
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These amounts were	paid in cash. o	or \square	credited.)	9c(2)		
		Status of policyholder reserves at end of year: (1) Amount held to				9d(1)		
		(2) Claim reserves	•			9d(2)		
		(3) Other reserves.				9d(3)		
		Dividends or retroactive rate refunds due. (Do not include amoun				9e		
10		nexperience-rated contracts:	it entered in line	30(2)	J.)	Je		
		Total premiums or subscription charges paid to carrier				10a		20985923
	_					100		20903923
	b	If the carrier, service, or other organization incurred any specific c retention of the contract or policy, other than reported in Part I, lin				10b		
	Spec	cify nature of costs.	e z above, repor	t aiii	ount	100		
	opo.	,						
Р	art l	V Provision of Information						
11	Did	the insurance company fail to provide any information necessary	to complete Sch	edule	e A?	Yes	X No)
		ne answer to line 11 is "Yes," specify the information not provided.			···			
		and the state of t	*					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

Pension Benefit Guar	anty Corporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				This Form is Open to Public Inspection			
For calendar plan ye	ar 2023 or fiscal p	an year beginning 01/01/2023		and ending 12/31/2023					
A Name of plan SETON HALL UNIV	ERSITY WELFAR	E BENEFIT PROGRAM		B Three-digit plan number (PN) ▶ 505					
C Plan sponsor's na SETON HALL UNIV			D Employer		ition Number (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 Informa	ation:								
(a) Name of insurant FIDELITY SECURITY (b) EIN			(e) Approximate no persons covered a	t end of	(f)	Policy or co	ontract year (g) To		
43-0949844	71870	1008322	policy or contract		1/01/2023		12/31/2023		
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code							(e) Organization code		
	(a) Name	and address of the agent, broke	er, or other person to who	n commissions	s or fees v	were paid			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid									
			ees and other commission	•					
(b) Amount of sales and base commissions paid (c) Amount				(d) Purpose			(e) Organization code		

Schedule A (Form 5500) 2	2023	Page 2 –	
	me and address of the agent, broke	er, 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
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		For and all an arranged to the second	(-)
(b) Amount of sales and base	4 > 4	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	y		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(a) Amount	·	Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, 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
p			

Pa	art	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	ridual contra	cts with each carrier may	be treated	l as a unit for purposes of
4 C	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5 C	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6 C	Cont	racts With Allocated Funds:				
á	а	State the basis of premium rates •				
ı	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 corretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
•	Э	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7 C	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in	separate accounts)		
ć	а	Type of contract: (1) deposit administration (2) immedia (3) guaranteed investment (4) other		tion guarantee		
ı	b	Balance at the end of the previous year			7b	
-	C	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	- (0)			
		(3) Interest credited during the year	- (-)			
		(4) Transferred from separate account	= (4)			
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	- (2)			
		(4) Other (specify below)	- (1)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

P	art III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report	group of employees of the						
		employees, the entire group of such individ							
8	_	t and contract type (check all applicable boxes)	_		_			_	
	a 📗	Health (other than dental or vision)	b Dental	(C X Vi	sion		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabili	ity (g∏ Su	upplemental unem	ployment	h Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	I	k∏ PF	PO contract		I Indemnity contract	ct
	m \Box	Other (specify)	- _		_				
	Ц	(-py)							
9	Experie	ence-rated contracts:							
	a Pre	emiums: (1) Amount received		9a(1)					
	(2) Increase (decrease) in amount due but unpaid	1	9a(2)					
	(3) Increase (decrease) in unearned premium res	erve	9a(3)					
	(4	e) Earned ((1) + (2) - (3))					9a(4)		
	b B	enefit charges (1) Claims paid		9b(1)					
	(2) Increase (decrease) in claim reserves		9b(2)			1		
	(3) Incurred claims (add (1) and (2))					9b(3)		
	,) Claims charged					9b(4)		
	C R	Remainder of premium: (1) Retention charges (o	n an accrual basis)	T.	-				
		(A) Commissions		9c(1)(A					
		(B) Administrative service or other fees		9c(1)(E					
		(C) Other specific acquisition costs		9c(1)(C					
		(D) Other expenses		9c(1)(E					
		(E) Taxes		9c(1)(E				_	
		(F) Charges for risks or other contingencies		9c(1)(F					
		(G) Other retention charges					9c/1\/U\		
	15	(H) Total retention	_		_		9c(1)(H)	<u> </u>	
		2) Dividends or retroactive rate refunds. (These					9c(2)		
		status of policyholder reserves at end of year: (1	•				9d(1)		
	•	2) Claim reserves					9d(2) 9d(3)		
	`	bividends or retroactive rate refunds due. (Do no					9e		
10		experience-rated contracts:	7 Include amount enteres	u III IIIIC 3 (<u> </u>				
. •		otal premiums or subscription charges paid to c	arrier				10a		85908
	_	the carrier, service, or other organization incurr							
		etention of the contract or policy, other than repo					10b		
	Specif	y nature of costs.							
D	art IV	Provision of Information							
								✓ N.	
11		he insurance company fail to provide any inform		lete Sched	dule A?		Yes	X No	
12	If the	answer to line 11 is "Yes," specify the informati	on not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

Pension Benefit Guaranty Co	rporation		companies are required to provide the information oursuant to ERISA section 103(a)(2).				This Form is Open to Public Inspection	
For calendar plan year 202	23 or fiscal pla	n year beginning 01/01/2023		and en	ding 12/3	31/2023		
A Name of plan	T. () A/E E A B E	DENIEUT DOGGANA	B Three-digit					
SETON HALL UNIVERSI	IY WELFARE	BENEFII PROGRAM		plan	number (Pi	N) •	505	
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identific	ation Number	(EIN)	
SETON HALL UNIVERSI				·	1500645			
		rning Insurance Contract						
1 Coverage Information:		J :						
(a) Name of insurance ca	rrier							
DELTA DENTAL OF NEW								
DELIA DENTAL OF NEW	OLINOLT, INO	•						
41 N E1 N I	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or o	contract year	
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To	
22-1896118	55085	07742	1932		01/01/202	3	12/31/2023	
2 Insurance fee and coming descending order of the		ation. Enter the total fees and tot	al commissions paid. Li	ist in line 3	the agents,	brokers, and o	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
		10457						
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all	persons).				
<u> </u>		and address of the agent, broker,			ions or fees	were paid		
MERCER HEALTH AND B		4565 P	PAYSPHERE CIRCLE GO, IL 60674					
		Fee	es and other commission	ns naid			<u> </u>	
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpose			(e) Organization code	
	10457	,		. / .			3	
	(a) Name a	and address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code	
							1	

Schedule A (Form 5500) 2	2023	Page 2 –				
	me and address of the agent, broke	er, 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			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
		For and all an arranged to the second	(-)			
(b) Amount of sales and base	4 > 4	Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
	y					
		(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base	(a) Amount	·	Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broke	er, 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			
p						

Pa	art	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	ridual contra	cts with each carrier may	be treated	l as a unit for purposes of
4 C	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5 C	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6 C	Cont	racts With Allocated Funds:				
á	а	State the basis of premium rates •				
ı	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 corretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
•	Э	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7 C	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in	separate accounts)		
ć	а	Type of contract: (1) deposit administration (2) immedia (3) guaranteed investment (4) other		tion guarantee		
ı	b	Balance at the end of the previous year			7b	
-	C	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	- (0)			
		(3) Interest credited during the year	- (-)			
		(4) Transferred from separate account	= (4)			
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	- (2)			
		(4) Other (specify below)	- (1)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Schedule A	/Earm	EEOO!	2022
Scriedule A	(FOIIII	5500	1 2023

Page 4

Part 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 individ	group of employees of the	tracts are	experien	ce-rated as a unit. Where	contrac	ts cover individual
8 Benefit a	and contract type (check all applicable boxes)						
	ealth (other than dental or vision)	b Dental		c Visi	ion	d∏	Life insurance
브	emporary disability (accident and sickness)	f ☐ Long-term disabi		느	oplemental unemployment	h □	Prescription drug
. =				- -		- '' ⊟	,
	top loss (large deductible)	j HMO contract	l	K PPC	O contract	' _	Indemnity contract
m _ C	Other (specify)						
9 Experier	nce-rated contracts:						
a Prer	niums: (1) Amount received		9a(1)		104573	30	
(2)	Increase (decrease) in amount due but unpai	db	9a(2)		-13	33	
` '	Increase (decrease) in unearned premium res					0	
(4)	Earned ((1) + (2) - (3))				9a(4))	1045597
b Be	nefit charges (1) Claims paid		9b(1)		85728	30	
` '	Increase (decrease) in claim reserves				490		
(3)	Incurred claims (add (1) and (2))				9b(3		862182
(4)	Claims charged				9b(4)	862182
C Re	mainder of premium: (1) Retention charges (c	n an accrual basis)					
	(A) Commissions		9c(1)(A	A)	1045	57	
	(B) Administrative service or other fees		9c(1)(E		1310	12	
	(C) Other specific acquisition costs		9c(1)(C	C)		0	
	(D) Other expenses		9c(1)(E	-		0	
	(E) Taxes		9c(1)(E			0	
	$(F)\ Charges\ for\ risks\ or\ other\ contingencies.$				1359	93	
	(G) Other retention charges		9c(1)(0	3)		0	
	(H) Total retention			<u></u>	9c(1)(H)	155062
(2)	Dividends or retroactive rate refunds. (These	e amounts were 📗 paid i	in cash, or	credit	ted.) 9c(2))	0
d Sta	itus of policyholder reserves at end of year: (1) Amount held to provide	e benefits a	 after retire	ement 9d(1)	0
(2)	Claim reserves				9d(2)	67868
` ,	Other reserves				2.1/2)	0
e Div	idends or retroactive rate refunds due. (Do n	ot include amount entere	ed in line 90	c(2).)	9e		0
	perience-rated contracts:				•		
a Tot	al premiums or subscription charges paid to o	carrier			10a		
b If th	ne carrier, service, or other organization incur	red any specific costs in	connection	with the	acquisition or		
	ention of the contract or policy, other than rep						
	nature of costs.						
	T						
Part IV	Provision of Information						
11 Did the	insurance company fail to provide any inforn	nation necessary to comp	olete Sched	dule A?	Yes	X N	lo
12 If the a	nswer to line 11 is "Yes," specify the informat	ion not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

Pension Benefit Guaranty	Corporation	pursuant to ERISA section 103(a)(2).				This For	his Form is Open to Public Inspection	
For calendar plan year 2	2023 or fiscal pla	in year beginning 01/01/2023		and en	ding 12/3	31/2023		
A Name of plan SETON HALL UNIVER	SITY WELFARE	BENEFIT PROGRAM		B Three	e-digit number (Pl	N) •	505	
C Plan sponsor's name SETON HALL UNIVERS		•	yer Identific 1500645	ation Number	EIN)			
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information 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 of ALPHA DENTAL PROGR								
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	or contract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f)	From	(g) To	
74-2447512	95163	78998	245		01/01/202	3	12/31/2023	
2 Insurance fee and co descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in	
(a) Total amount of commissions paid				(b) To	otal amount	of fees paid		
		361						
3 Persons receiving co		fees. (Complete as many entrie						
MERCER HEALTH AND			er, or other person to who PAYSPHERE CIRCLE CAGO, IL 60674	m commiss	ions or fees	were paid		
			ees and other commission	ns naid				
(b) Amount of sales commissions p	I	(c) Amount		(d) Purpose	е		(e) Organization code	
	361						3	
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid		
	Υ	,	,			'		
(b) Amount of sales	and base	F	ees and other commission	ns paid				
commissions paid		(c) Amount		(d) Purpose	е		(e) Organization code	

Schedule A (Form 5500) 2	2023	Page 2 –				
	me and address of the agent, broke	er, 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			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
		For and all an arranged to the second	(-)			
(b) Amount of sales and base	4 > 4	Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
	y					
		(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base	(a) Amount	·	Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broke	er, 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			
p						

Pa	art	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	ridual contra	cts with each carrier may	be treated	l as a unit for purposes of
4 C	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5 C	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6 C	Cont	racts With Allocated Funds:				
á	а	State the basis of premium rates •				
ı	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 corretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
•	Э	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7 C	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in	separate accounts)		
ć	а	Type of contract: (1) deposit administration (2) immedia (3) guaranteed investment (4) other		tion guarantee		
ı	b	Balance at the end of the previous year			7b	
-	C	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	- (0)			
		(3) Interest credited during the year	- (-)			
		(4) Transferred from separate account	= (4)			
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	- (2)			
		(4) Other (specify below)	- (1)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

P	art I	Welfare Benefit Contract Informati If more than one contract covers the same gro the information may be combined for reporting employees, the entire group of such individua	oup of employees of th g purposes if such con	tracts are	exp	erience-rated as a uni	t. Where co	ontracts cover in	
8	Bene	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	Dental		С	Vision		d Life insu	rance
	еĪ	Temporary disability (accident and sickness) f	Long-term disabil	itv	g	Supplemental unem	plovment	h Prescrip	tion drua
	i	Stop loss (large deductible)	HMO contract	,	k	PPO contract	····	_ H	y contract
	· _	<u>-</u>	Timo contract			1110 contract		• I I III deliliili	y contract
	m _	Other (specify)							
_									
9	•	erience-rated contracts:		0-/4					
		Premiums: (1) Amount received		9a(1	•			_	
		(2) Increase (decrease) in amount due but unpaid		9a(2				-	
		(3) Increase (decrease) in unearned premium reser		9a(3			00(4)		
	_	(4) Earned ((1) + (2) - (3))					. 9a(4)		
		Benefit charges (1) Claims paid		9b(1	•			-	
		(2) Increase (decrease) in claim reserves					0h/2\		
		(3) Incurred claims (add (1) and (2))					9b(3)		
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on a	,	0-(4)/	A \				
		(A) Commissions		9c(1)(_	
		(B) Administrative service or other fees		9c(1)(_	
		(C) Other specific acquisition costs		9c(1)(-			_	
		(D) Other expenses		9c(1)(_	
		(E) Taxes		9c(1)(9c(1)(-			-	
		(F) Charges for risks or other contingencies		9c(1)(_			-	
		(G) Other retention charges					00/41/141		
		(H) Total retention	_		_		9c(1)(H))	
		(2) Dividends or retroactive rate refunds. (These ar	ш -		_		9c(2)		
		Status of policyholder reserves at end of year: (1) A	•				9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
		Dividends or retroactive rate refunds due. (Do not	include amount entere	d in line 9)c(2)	.)	9e		
10		nexperience-rated contracts:							
	а	Total premiums or subscription charges paid to care	rier				10a		36084
	b	If the carrier, service, or other organization incurred					406		
	Snor	retention of the contract or policy, other than reported to the result of the result o	ed in Part I, line 2 abov	ve, report	amo	ount	10b		
	Spec	shy flature of costs.							
Р	art I	V Provision of Information							
11	Did	the insurance company fail to provide any informat	ion necessary to comp	lete Sche	dule	A?	Yes	X No	
12	lf th	ne answer to line 11 is "Yes," specify the information	n not provided.						
		· · · · · ·							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

Pension Benefit Guaranty Co		Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection		
For calendar plan year 202	23 or fiscal plar	year beginning 01/01/2023		and e	nding 12/3	1/2023	
A Name of plan SETON HALL UNIVERSI	TY WELFARE	BENEFIT PROGRAM			ee-digit n number (PN) •	505
SETON HALL UNIVERSITY 22-1					oyer Identifica		` <i>'</i>
		ning Insurance Contract. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca STANDARD INSURANCE	COMPANY	I	(e) Approximate no	ımher of	1	Policy or o	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	t end of	(f)	From	(g) To
93-0242990	69019	170601	1321	,	01/01/2023	}	12/31/2023
2 Insurance fee and com- descending order of the		ation. Enter the total fees and to	tal commissions paid. L	st in line 3	the agents, t	prokers, and o	other persons in
(a) Total a	amount of comi	missions paid		(b) T	otal amount o	of fees paid	
		10628					11031
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker		n commis	sions or fees	were paid	
RSC INSURANCE BROKE	ERAGE INC		OX 970069 ON, MA 02297				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	se		(e) Organization code
		11031	CONTINGENT COMPEN	SATION			3
	(a) Name a	nd address of the agent, broker	or other person to who	m commiss	sions or fees	were paid	
MERCER HEALTH AND B		1717	ARCH STREET, 11TH F		SIONS OF ICES	were paid	
(b) Amount of sales ar	nd hase	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	5489						3

(b) Amount of sales and base commissions paid

Schedule A (Form 5500) 2023		Page 2 –	
(a) Name a	nd address of the agent, broker, o	or other person to whom commissions or fees were pa	aid
MERCER HEALTH AND BENEFITS, LLC	4565 PA	AYSPHERE CIRCLE GO, IL 60674	
	Fe	ees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
5138			3
(a) Name a	nd address of the agent, broker, o	or other person to whom commissions or fees were pa	aid
	Fe	ees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Name a	nd address of the agent, broker, o	or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base	Fe	ees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	ees and other commissions paid (d) Purpose	(e) Organization code
			Organization
commissions paid	(c) Amount		Organization code
commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Name a	(c) Amount	(d) Purpose	Organization code
commissions paid	(c) Amount	(d) Purpose or other person to whom commissions or fees were pa	Organization code
(a) Name a	(c) Amount	(d) Purpose or other person to whom commissions or fees were pa	Organization code aid (e) Organization

Fees and other commissions paid

(c) Amount

(d) Purpose

(e) Organization code

Pa	art	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	ridual contra	cts with each carrier may	be treated	l as a unit for purposes of
4 C	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5 C	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6 C	Cont	racts With Allocated Funds:				
á	а	State the basis of premium rates •				
ı	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 corretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
•	Э	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7 C	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in	separate accounts)		
ć	а	Type of contract: (1) deposit administration (2) immedia (3) guaranteed investment (4) other		tion guarantee		
ı	b	Balance at the end of the previous year			7b	
-	C	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	- (0)			
		(3) Interest credited during the year	- (-)			
		(4) Transferred from separate account	= (4)			
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	- (2)			
		(4) Other (specify below)	- (1)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Schedule A	/Earm	EEOO!	2022
Scriedule A	(FOIIII	5500	<i> </i>

Page 4

Part III	If more than one contract covers the same the information may be combined for report	group of employees of thing purposes if such con	tracts are	experi	ience-rated as a unit. Where	contrac	ts cover individual
•	employees, the entire group of such individ		amer may	y be tre	eated as a unit for purposes of	יווא וכ	eport.
8 Benef	it and contract type (check all applicable boxes)	_		_			•
a 📗	Health (other than dental or vision)	b Dental		c 🗌 ,	Vision	d 🗙	Life insurance
е 🗌	Temporary disability (accident and sickness)	f Long-term disabil	lity	g 🗌 🤅	Supplemental unemployment	: h	Prescription drug
i	Stop loss (large deductible)	j HMO contract		k∏ı	PPO contract	ıΠ	Indemnity contract
m 🛚	Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT					
^	Other (specify)						
9 Evneri	ence-rated contracts:						
•	remiums: (1) Amount received		9a(1)	\	2569	21	
	2) Increase (decrease) in amount due but unpaid		9a(2)		5029		
•	B) Increase (decrease) in unearned premium res				502	0	
	4) Earned ((1) + (2) - (3))				9a(4		307214
	Benefit charges (1) Claims paid				2550		
	2) Increase (decrease) in claim reserves			_	604		
,	B) Incurred claims (add (1) and (2))						315465
•	4) Claims charged						315465
,	Remainder of premium: (1) Retention charges (c						
•	(A) Commissions	•	9c(1)(A)	216	58	
	(B) Administrative service or other fees		9c(1)(l		210	0	
	(C) Other specific acquisition costs		9c(1)(644		
	(D) Other expenses		9c(1)(I		360		
	(E) Taxes		9c(1)(I		61:		
	(F) Charges for risks or other contingencies		9c(1)(I		135		
	(G) Other retention charges		0.7417			0	
	(H) Total retention				9c(1)((H)	141872
(Dividends or retroactive rate refunds. (These						0
	Status of policyholder reserves at end of year: (1			_		•	0
	2) Claim reserves					•	60465
,	3) Other reserves					•	0
,	Dividends or retroactive rate refunds due. (Do n						0
	experience-rated contracts:			- () /			
	otal premiums or subscription charges paid to c	arrier			10a		
_	f the carrier, service, or other organization incur						
r	etention of the contract or policy, other than rep	orted in Part I, line 2 abo	ve, report	amour	nt	,	
	fy nature of costs.	,	, ,				
•							
Part IV	Provision of Information						
11 Did t	he insurance company fail to provide any inform	nation necessary to comm	olete Sche	dule A	.?Yes	X N	lo
	e answer to line 11 is "Yes," specify the informat		50110	2010 M			
iz ii ine	answer to line it is ites, specify the informat	ion not provided. 🔻					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

Pension Benefit Guaranty Co	pursuant to ERISA section 103(a)(2).				rm is Open to Public Inspection		
For calendar plan year 20	23 or fiscal pla	n year beginning 01/01/2023		and en	iding 12/3	31/2023	
A Name of plan				B Thre	e-digit		
SETON HALL UNIVERSI	TY WELFARE	BENEFIT PROGRAM		plan	number (Pi	N) •	505
				·	,	•	
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identific	ation Number	(EIN)
SETON HALL UNIVERSI	TY			22-	1500645		
		rning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca							
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or o	contract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
93-0242990	69019	170601	1339		01/01/202	3	12/31/2023
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and o	other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount	of fees paid	
		12767					11064
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all	persons).			
-		and address of the agent, broker			ions or fees	were paid	
EMERSON ROGERS LLC		669 RI SUITE	IVER DRIVE CENTER				
(b) Amount of sales ar	ad bass	Fe	es and other commissio	ns paid			
commissions pa		(c) Amount	(d) Purpose				(e) Organization code
	7342	11064 C	CONTINGENT COMPEN	ISATION			3
	(a) Name a	and address of the agent, broker	or other person to who	m commiss	ione or fees	were paid	<u> </u>
DEC INCLIDANCE PROVE	(4.)		X 970069	III COIIIIII33	ions or ices	were paid	
RSC INSURANCE BROKE	ERAGE INC		ON, MA 02297				
(b) Amount of sales ar	nd base	Fe	es and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	5425						3
							1

Schedule A (Form 5500) 2	2023	Page 2 –	
	me and address of the agent, broke	er, 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
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		For and all an arranged to the second	(-)
(b) Amount of sales and base	4 > 4	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	y		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(a) Amount	·	Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, 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

Pa	art	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	ridual contra	cts with each carrier may	be treated	l as a unit for purposes of
4 C	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
5 C	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6 C	Cont	racts With Allocated Funds:				
á	а	State the basis of premium rates •				
ı	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 corretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
•	Э	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7 C	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in	separate accounts)		
ć	а	Type of contract: (1) deposit administration (2) immedia (3) guaranteed investment (4) other		tion guarantee		
ı	b	Balance at the end of the previous year			7b	
-	C	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	- (0)			
		(3) Interest credited during the year	- (-)			
		(4) Transferred from separate account	= (4)			
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	- (2)			
		(4) Other (specify below)	- (1)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Р	art III	Welfare Benefit Contract Informal If more than one contract covers the same the information may be combined for report	group of employees of the						
		employees, the entire group of such individ							
8	Benefit	and contract type (check all applicable boxes)	_		_			_	
	a 📗	Health (other than dental or vision)	b Dental		С	Vision		d ∐ Li	fe insurance
	е 🗌	Temporary disability (accident and sickness)	f X Long-term disabili	ty	g	Supplemental unem	ployment	h 🗌 P	rescription drug
	i	Stop loss (large deductible)	j HMO contract		kΠ	PPO contract		I n	demnity contract
	m 🗍	Other (specify)	- 🗖						
	Ц	(-p) /							
9	Experie	ence-rated contracts:							
	a Pre	emiums: (1) Amount received		9a(1))		146848		
	(2)) Increase (decrease) in amount due but unpaid	l	9a(2))		28725		
	(3)) Increase (decrease) in unearned premium res	erve	9a(3)			C		
	(4)) Earned ((1) + (2) - (3))					. 9a(4)		175573
	b Be	enefit charges (1) Claims paid		9b(1)			25158		
	` ') Increase (decrease) in claim reserves		<u>`</u>			665617	,	
	(3)	Incurred claims (add (1) and (2))					9b(3)		690775
	, ,) Claims charged					9b(4)		690775
	C R	emainder of premium: (1) Retention charges (o	n an accrual basis)						
		(A) Commissions		9c(1)(23831		
		(B) Administrative service or other fees		9c(1)(l			C		
		(C) Other specific acquisition costs		9c(1)((39276		
		(D) Other expenses		9c(1)(I 9c(1)(I			27987		
		(E) Charges for risks or other contingencies		9c(1)(l			1844		
		(F) Charges for risks or other contingencies (G) Other retention charges		9c(1)(_		10004 C		
		(H) Total retention					9c(1)(H		102942
	(2	Dividends or retroactive rate refunds. (These	_		$\overline{}$			'	0
		tatus of policyholder reserves at end of year: (1			_		9c(2) 9d(1)		0
		Claim reserves	•				9d(1)	+	665617
	•	Other reserves					9d(3)		0
	`	ividends or retroactive rate refunds due. (Do no					9e		0
10		xperience-rated contracts:	or molado amount omoro.	<u> </u>	<u> </u>	,	, ,,		
. •		otal premiums or subscription charges paid to c	arrier				10a		
	_	the carrier, service, or other organization incurr							-
		tention of the contract or policy, other than repo					10b		
		y nature of costs.		•				•	
D	art IV	Provision of Information							
) _V	V NI	
11		ne insurance company fail to provide any inform		ete Sche	dule	A?	Yes	X No	
12	If the	answer to line 11 is "Yes," specify the informati	on not provided.						

Carriers' Schedules

have reviewed the Carrier Schedules.

The following document(s) are the Schedules from the Carrier(s) of the Plan Sponsor's ERISA Plan.

These documents represent a snap shot taken on the last day of the policy period per the Carriers' systems. The data was copied and placed into the Plan Sponsor's 5500 report.

Please note: If the data was altered in any way, the liability of the data will no longer rest on the Carrier; instead, it would rest upon the Plan Sponsor/Plan Administrator.

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February 28, 2024

SETON HALL UNIVERSITY TERRI DEMAREST 400 SOUTH ORANGE AVE SOUTH ORANGE, NJ-07079

Dear Policyholder:

We've attached your certified Annual Statement of Premiums and Producer Compensation group benefits summary. The summary is useful when completing and filing an IRS Form 5500 Schedule A. The Hartford certifies the accuracy and completeness of the information provided.

To help you better understand your statement, we've defined some of the terms used in the report.

calculation of any such additional compensation	
for additional compensation and/or the actual	
considered in determining the producer's eligibility	
payable to producers on all policies that were	Record as "Fees" on IRS Form 5500 Schedule A
Non-contingent compensation (cash or non-cash)	Additional Compensation
any such bonus payment	
for bonus payments and/or the actual calculation of	
considered in determining the producer's eligibility	
payable to producers on all policies that were	Record as "Fees" on IRS Form 5500 Schedule A
Contingent compensation (cash or non-cash)	Bonus Pald
including General Agent override compensation.	****
administrative or other services related to your policy	Record as "Fees" on IRS Form 5500 Schedule A
Payments to your insurance producer for	Fees
received and applied during the policy year	
Base paid to your insurance producer on premiums	Commissions
Payments paid and applied during the policy year	smuimen9
DEFINITION:	TERM:

We appreciate your business and look forward to continuing to serve your group benefits needs. If you need additional information, please contact your Hartford representative or call Customer Service at (800) 523-8233 or via e-mail gbdcommissions@hartfordlife.com.

Sincerely,

Jonathan Pintoff
Assistant Vice President
Service Operations
P.O. Box 2999
Hartford, CT 06104-2999

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The Hartford Group Benefits Division Annual Statement of Premiums and Producer Compensation

For: SETON HALL UNIVERSITY Page: 1 of 2

Policyholder and Address

SETON HALL UNIVERSITY
400 SOUTH ORANGE AVE
SOUTH ORANGE, NJ-07079

MAR 1 1 2024

Received

Human Resources

Plan/Policy Year - 01/1/2023 to 12/31/2023

₽78802GGA	21807	8498680-90	HARTFORD LIFE AND ACCIDENT
Policy Number	NAIC Code	EIN	Name of Insurance Carrier

Premium was applied as follows during the Plan/Policy Year -

	\$1,012,30	Total	
SEE POLICYHOLDER RECORDS	\$1,012,30	ACCIDENTAL DEATH & DISMEMBERMENT	478802GGA
			-
Lives Covered			
No # stamixorqqA	Premium Applied	Type of Benefit	Policy Number

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The Hartford Group Benefits Division Annual Statement of Premiums and Producer Compensation

For: SETON HALL UNIVERSITY
Page: 2 of 2

Insurer paid the following compensation during the Plan/Policy Year -

(2)Additional Compensation Baid	bis q suno B(1)	Fees Paid	Commissions Paid	Policy Number	grO Code	Producer and Address
00.0\$	00.0 \$	00.0\$	Z9'09 \$	₽7880≳QQA	ω	MERCER HEALTH & BENEFITS LLC 1166 AVENUE OF THE AMERICAS, 34TH FLOOR NEW YORK, NY-10036
00'0\$	00.0 \$	00.0\$	Z9.03 \$	Total		

(1)Bonus Paid represents an allocation of contingent compensation (cash or non-eash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such bonus payment. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

(2) Additional Compensation represents an allocation of non-contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such additional compensation. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

The Harford compensates producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation and growth of premium, overall profitability, or other performance measures. Some of our producers elect not to accept some or all forms of compensation from The Harford. Please direct specific questions about your insurance producer's compensation to your producer.

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Cigna Health and Life Insurance Company

A Cigna company Hartford, CT 06152



Schedule A Insurance Information Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator						
A. Plan Name SETON HALL UNIVERSITY						rill Provide
C. Plan Sponsor's Nan		will Provide			rill Provide	
Part I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)						
1. Coverage Information (a) Name of Insurance Carrier:Cigna Health and Life Insurance Company and affiliates ("Cigna") (b) Approx po of persons covered Policy/Contract Year						
(b) EIN (c) 59-1031071	` I \ ` I Identification Number		(e) Approx.no.of persons covered at end of policy or contract year 1,025 Employees		(f) From 01/01/2023	/Contract Year (g) To — 12/31/2023
2. Insurance fees and commissions information. Enter total fees and commissions paid						
(a) Total Amount of commissions paid \$0			(b) Total Amount of fees paid \$210,776			
3. Persons receiving commissions and fees.			Fees and commissions paid			
(a) Name and address of the agent, broker or other person to who commissions and fees were paid		(b) Amount of sales and base commissions paid	(c) Amount*	(d) F	Purpose*	(e) Organization code
Non Experience - Rated			*Refer to footnotes for incentive \$\$ amounts and purpose as applicable		ounts and	
MERCER HEALTH & BENEFITS,4565 PAYSPHERE CIR,CHICAGO,IL,60674		\$0	\$209,824	Benefit Advisc	r Payments	3- Insurance Agent or Broker
Part II Investment an	nd Annuity Contract Inf	formation	This section not applicable to this Plan			
Outstanding Monies Due > (\$32,649) contract number of identification > same as 1d						
Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.						
Benefit and Contract information		than dental or vision) (b sability (accident and) □ Dental	(c) 🗖 Vision	า (d) 🛘 Life Insurance
	sickness)	(f)) 🛘 Long-Term d	isability (g) 🗖 Supp	lemental Unemply (h) 🛘 Prescription drug
		pp Loss (Large deductible) (j) ☐ HMO contract (k) ☐ PPO Contract (l) ☑ Indemnity) 🗹 Indemnity contract
9. Experience-Rated C		,	This section not applicable for this Plan			
10. Nonexperience- rated contracts	(a) Total premiums	or subscriptions charges pa	id to carrier			\$20,985,923
	Premium Due as of	f			02/26/2024	(\$32,649)
	(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, item 2 above, report amount					
Specify nature of costs						
PART IV Provision of Information						
11. Did the insurance company fail to provide any information necessary to complete Schedule A?						
12. If the answer to line 11 is "Yes", specify the information not provided. > Answer "Not Applicable"						ilicable"
Comments						
THE INFORMATION REFLECTED IN THIS REPORT IS ACCURATE AND COMPLETE BASED UPON INFORMATION AVAILABLE TO CIGNA COMPANIES						

AT THE TIME THIS REPORT IS PREPARED AND IS CERTIFIED AS BEING COMPLETE AND ACCURATE.

NOTE TO POLICYHOLDERS: You may have responsibilities under law to determine whether the information contained in this report could be used to identify individuals either when combined with other information that you have or in any other manner and, if so, to take appropriate protective steps.

[&]quot;Cigna" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by such operating subsidiaries and not Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

Cigna Health and Life Insurance Company

A Cigna company Hartford, CT 06152



Schedule A Insurance Information - Footnotes Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator B. Three-Digit Plan #(PN) SETON HALL UNIVERSITY A. Plan Name Plan will Provide C. Plan Sponsor's Name: D. Company Identification Number: Plan will Provide Plan will Provide Part I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III) Name of Insurance Carrier:Cigna Health and Life Insurance Company and affiliates ("Cigna" 1. Coverage Information (a) Policy/Contract Year Contract or (e) Approx no of persons covered NAIC Code (b) EIN (f) From (g) To Identification Number at end of policy or contract year 59-1031071 67369 3334085 1,025 **Employees** 01/01/2023 12/31/2023

Part I, line 1a: "Name of Insurance Carrier", (b) "EIN", (c) "NAIC Code" - The plan to which this report applies may be funded by contracts issued by more than one Cigna company each of which is an "insurance carrier." The issuance of multiple insurance carrier contracts is necessary to cover individuals who participate in the same plan but reside in different geographic locations. As the Cigna companies whose contracts fund the plan are grouped as a single unit by Cigna for purposes of underwriting the plan, combining the information with respect to these individual contracts in this report will provide more meaningful insurance information for the Schedule A. The individual contracts of the Cigna companies are grouped as a unit for purposes of this report. To reference individual contracts please refer to the Schedule A Appendix pages contained within this reporting package, if applicable.

Part I, line 2a, 2b: The following amounts were paid to your broker(s) / consultant(s) during the contract year:

Commissions: \$0 General Agent Fees: \$0 Benefit Advisor Fees: \$209,824

Part I, line 3c: Incentive compensation payments based upon persons/members in your plan and/or lump sum amount: \$952 (Broker and General Agents combined) attributable to your plan for the 2023 calendar year. These amounts are funded from Cigna companies general overhead. Contact your broker/consultant for further details.

In addition to the Commissions/Benefit Advisor Fees reported, Cigna enters into compensation programs under which certain agents and brokers provide our companies with market intelligence produce and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific policies, is funded form our general overhead, and is not required to be reported on Schedule A. Your agent or broker may also have participated at our expense, in events we sponsor to inform them on our products and services. Contact your agent/broker for specific information about their participation.

The contract holder is not entitled to a return of any premium or other payment made to Cigna company unless the Cigna company agrees otherwise in writing. The Cigna companies may use payments received for any purpose in its sole discretion.

If the contract holder is a Public Entity located in California, you are asked to forward this report to the governing board.

Part 1, line 2a, 2b, 3b and/or 3c: Represents the amount of Commissions/Benefit Advisor Fees paid during the contract year. This amount is reflective of payments made during the contract year that may be attributable to multiple contract years.

Part 1, line 3b and/or c: May include prior year Commissions/Benefit Advisor Fees not previously reported.

Part 1, line 3b and/or c: There may be adjustments made to Commissions and/or Benefit Advisor Fee payments outside the policy period that are not reflected on this form

Line 10a: May reflect amounts paid for surcharges on provider charges or other assessments imposed under applicable state law.

Line 10a: Includes payments by State Continuants of \$0administered by Cigna and applicable to your account.

- If applicable and provided with this reporting, the Appendix to Schedule A entities' allocation is based on averaged premium, Commissions/Benefit Advisor Fees and available lives.
- If applicable and provided with this reporting, the Appendix to Schedule A entities' allocation for broker/general agent Commission/Benefit Advisor Fee amounts do not include Platinum/Supplemental bonus payments as they are paid lump sum to brokers/general agents and are included on the Schedule A summary page reporting.
- If applicable and provided with this reporting, the Appendix to Schedule A entities' reports the number of employees covered rather than employees and dependents. Subscriber and membership information is available for your contract policy year on the employer portal at www.cignaaccess.com, report titled, Subscriber and Membership Reporting.
- The premium reported does not reflect the rebates, if any, under the Patient Protection and Affordable Care Act that may have been paid for any prior plan year.
- Premium also includes taxes, fees and assessments imposed under the Patient Protection and Affordable Care Act,

Vision Insurance Information For Form 5500

Information Compiled By: EyeMed Vision Care on behalf of the Fidelity Security Life Insurance Company

Report End Date	12/31/2023
Report Start Date	1/1/2023

Payments Received by carrier from plan or plan sponsor:

Name of Plan	Contract or ID #	Enrollment Group	Approximate number of persons covered at end of policy or contract year:	EIN	NAIC	Amount
SETON HALL UNIVERSITY	10083221001	SETON HALL UNIVERSITY	2,202	430949844 71870	71870	\$85,392.83
SETON HALL UNIVERSITY	10083221002	SETON HALL UNIVERSITY COBRA	17	430949844	71870	\$515.30
SETON HALL UNIVERSITY COBRA	10540081001	SETON HALL UNIVERSITY COBRA	0		71870	\$0.00
			2,219		Total:	\$85,908.13

Commissions or fees paid by carrier to agents, brokers or other persons:

Amount	
Commission Type Code	
Zip Code	
State	
City	
Address Line 1	
Payee Name	

Form 5500 - Insurance Information

Plan sponsor's na	ime:	SETON HALL UNI	VERSITY				
Part I	Information Cond	erning Insurance	Contract Coverage, Fees, and	Commissions			
1 Coverage inform	nation:	-					
(a) Name of insura	nce carrier:	DELTA DENTAL OF	NEW JERSEY, INC.				
	(e) Approximate number of persons		Policy or cor	itract year			
(b) EIN	(c) NAIC code	(d) Cont	ract or identification number	covered at end of	policy or contract	(f) Erom	(a) To
				ye	ar	(f) From	(g) To
22-1896118	55085		07742	Total Subscribers 917	Total Members 1,932	1/1/23	12/31/23
2 Insurance fee a	nd commission info	rmation		!			
(a) Total amount o	f commission paid:		\$10,457				
3 Persons receiving	ng commissions and	fees					
(a) Name and addr	ess of the agent, br	oker, or other pers	on to whom commissions or fees	were paid			
Name:	MERCER HEALTH &	BENEFITS,LLC		Name:			
Address Line 1:	4565 PAYSPHERE C	IRCLE		Address Line 1:			
Address Line 2:				Address Line 2:			
Address Line 3:				Address Line 3:			
City, State Zip:	CHICAGO, IL 60674			City, State Zip:			
Amount:	\$10,457			Amount:			
Name:				Name:			
Address Line 1:				Address Line 1:			
Address Line 2:				Address Line 2:			
Address Line 3:				Address Line 3:			
City, State Zip:				City, State Zip:			
Amount:	l			Amount:			
Part III 8 Benefit and co	Welfare Benefit C	ontract informat	ion				
	**	١	b ☑ Dental	c 🗖 Vision		d 🗖 1 ifa inaurana	
	r than dental or vision					d Life insurance	
	isability (accident and	sicknessj	f ☐ Long-term disability j ☐ HMO contract	g □ Supplemental ur k □ PPO contract	iempioyment	h Prescription drug	
i ☐ Stop loss (lar m ☐ Other (speci) in Histo contract	K 🗖 PPO contract		I Indemnity contra	et.
9 Experience-rat							
					9a(1)	\$1,045,730	
					9a(2)	-\$133	
	=	· ·	e		9a(3)	\$0	
	•	•			34(3)	. 9a(4)	\$1,045,598
					9b(1)	\$857,280	\$1,0 13,330
_					9b(2)	\$4,902	
					• • • • • • • • • • • • • • • • • • • •	9b(3)	\$862,182
						9b(4)	\$862,182
	premium: (1) Reten					` ` ` `	
(A) Commi	issions				9c(1)(A)	\$10,457	
(B) Admini	istrative service or o	ther fees			9c(1)(B)	\$131,012	
(C) Other s	specific acquisition o	osts			9c(1)(C)	\$0	
(D) Other	expenses				9c(1)(D)	\$0	
(E) Taxes					9c(1)(E)	\$0	
(F) Charge:	s for risks or other c	ontingencies			9c(1)(F)	\$13,593	
(G) Other I	Retention Charges				9c(1)(G)	\$0	
(H) Total R	tetention					9c(1)(H)	\$155,062
(2) Dividends	or retroactive rate	refunds. (These am	ounts were 🗖 paid in cash, or 🗵	l credited.)		9c(2)	\$0
d Status of polic	cyholder reserves at	end of year: (1) An	nount held to provide benefits at	retirement		9d(1)	
(2) Claims res	serves					. 9d(2)	\$67,868
(3) Other reserves				. 9d(3)			
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)							
•	ice-rated contracts:						
a Total premiums or subscription charges paid to carrier				10a			
	· -		y specific costs in connection with	•		10b	
or retention of the contract or policy, other than reported in Part I, line 2 above, report amount							

This statement contains only the data necessary to complete your Form 5500. It does not represent the actual form. For further information about filing, please contact your attorney or tax consultant.



Form 5500 - Insurance Information

Group Name: SETON HALL UNIVERSITY

Group Number: 78998

Division Number:

Number of Subscribers: 117

Number of Members: 245

Commissions Paid: \$360.79

Plan Year: 01/01/2023 -12/31/2023

Premium Paid: \$36,084.13

Carrier: Alpha Dental Programs, Inc.

Delta EIN: 74-2447512

Delta NAIC: 95163

This statement contains only the data necessary to complete your Form 5500. It does not represent the actual form. For further information about filing, please contact your attorney or tax consultant.

APPENDIX

BROKER COMMISSIONS

Broker Name: \$Commissions Paid:

MERCER HEALTH & BENEFITS LLC \$360.79



LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500 IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: SETON HALL UNIVERSITY

PART I

1) COVERAGE - LIFE INSURANCE

The Standard

a) CARRIER: STANDARD INSURANCE COMPANY

b) EIN: 93-0242990
c) NAIC CODE: 000-69019
d) CONTRACT NUMBER: 170601
e) NUMBER OF PERSONS COVERED: 1,321
f) FROM: 1/1/2023
g) TO: 12/31/2023

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

AMOUNT OF COMMISSIONS PAID: \$21,658.24 FEES PAID / AMOUNT: \$0.00

A) NAME & ADDRESS OF AGENT OR	B) AMOUNT OF COMMIS	B) AMOUNT OF COMMISSION PAID		FEES PAID	
BROKER TO WHOM COMMISSION OR FEES WERE PAID	COMMISSIONS	CONTINGENT COMP*	C) AMOUNT	D) PURPOSE	CODE
RSC INS BROKERAGE INC PO BOX 970069 BOSTON, MA 02297	\$0.00	\$11,030.71	\$0.00		3
MERCER HEALTH & BENEFITS 4565 PAYSPHERE CIRCLE CHICAGO, IL 60674	\$5,138.43	\$0.00	\$0.00		3
MERCER HEALTH & BENEFITS 1717 ARCH ST 11TH FLOOR PHILADELPHIA, PA 19103	\$5,489.10	\$0.00	\$0.00		3
	TOTAL COMMISSIONS DAID	`	¢10 627 52		

TOTAL COMMISSIONS PAID \$10,627.53

TOTAL CONTINGENT COMP PAID \$11,030.71

^{*&#}x27;Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

LONG FORM INFORMATION

PART III - 170601

7) BENEFIT TYPE: LIFE INSURANCE

EXPERIENCE RATED CONTRACTS

a) PREMIUMS: (1) AMOUNT RECEIVED \$256,921.15
(2) INCREASE (DECREASE) IN DUE BUT UNPAID \$50,293.00

(3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE \$0.00

(4) EARNED PREMIUM ((1) +(2) - (3)) \$307,214.15

b) BENEFIT CHARGES: (1) CLAIMS PAID \$255,000.00

(2) INCREASE (DECREASE) CLAIM RESERVES \$60,465.00

INCURRED CLAIMS ((1) +(2)) \$315,465.00

(4) CLAIMS CHARGED \$315,465.00

c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES

(A) COMMISSIONS \$21,658.24

(B) ADMINISTRATIVE SERVICE OR OTHER FEES \$0.00

(C) OTHER SPECIFIC ACQUISITION COSTS \$64,499.00

(D) OTHER EXPENSES \$36,011.61

(E) TAXES \$6,155.57

(F) CHARGES FOR RISK OR OTHER CONTINGENCIES \$13,547.29

(G) OTHER RETENTION CHARGES \$0.00

(H) TOTAL RETENTION \$141,871.72

(2) DIVIDEND OR RETROACTIVE RATE REFUND

d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR

(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT \$ 0.00

(2) CLAIM RESERVES \$60,465.00

(3) OTHER RESERVES \$0.00

(E) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE \$0.00



LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500 IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: SETON HALL UNIVERSITY

PART I

1) COVERAGE - LONG TERM DISABILITY

The Standard

a) CARRIER: STANDARD INSURANCE COMPANY

b) EIN: 93-0242990
c) NAIC CODE: 000-69019
d) CONTRACT NUMBER: 170601
e) NUMBER OF PERSONS COVERED: 1,339
f) FROM: 1/1/2023
g) TO: 12/31/2023

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

AMOUNT OF COMMISSIONS PAID: \$23,831.27 FEES PAID / AMOUNT: \$0.00

A) NAME & ADDRESS OF AGENT OR	B) AMOUNT OF COM	MISSION PAID	FEES PAID		
BROKER TO WHOM COMMISSION OR FEES WERE PAID	COMMISSIONS	CONTINGENT COMP*	C) AMOUNT	D) PURPOSE	CODE
RSC INS BROKERAGE INC PO BOX 970069 BOSTON, MA 02297	\$5,424.72	\$0.00	\$0.00		3
EMERSON ROGERS LLC 669 RIVER DRIVE SUITE 305 ELMWOOD PARK, NJ 07407	\$7,342.43	\$11,064.12	\$0.00		3

TOTAL COMMISSIONS PAID \$12,767.15
TOTAL CONTINGENT COMP PAID \$11,064.12

^{*&#}x27;Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

Docusign Envelope ID: DBCF3277-1D6B-472F-BC22-FAB93A3F3E72 FOR THE PERIOD OF 1/1/2023 TO 12/31/2023

LONG FORM INFORMATION

PART III - 170601

7) BENEFIT TYPE: LONG TERM DISABILITY

EXPERIENCE RATED CONTRACTS

a) PREMIUMS: (1) AMOUNT RECEIVED \$146,848.41

(2) INCREASE (DECREASE) IN DUE BUT UNPAID \$28,725.00

(3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE \$0.00

(4) EARNED PREMIUM ((1) +(2) - (3)) \$175,573.41

b) BENEFIT CHARGES: (1) CLAIMS PAID \$25,157.86

(2) INCREASE (DECREASE) CLAIM RESERVES \$665,616.83

INCURRED CLAIMS ((1) +(2)) \$690,774.69

(4) CLAIMS CHARGED \$690,774.69

c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES

(A) COMMISSIONS \$23,831.27

(B) ADMINISTRATIVE SERVICE OR OTHER FEES \$0.00

(C) OTHER SPECIFIC ACQUISITION COSTS \$39,276.00

(D) OTHER EXPENSES \$27,987.09

(E) TAXES \$1,843.53

(F) CHARGES FOR RISK OR OTHER CONTINGENCIES \$10,003.88

(G) OTHER RETENTION CHARGES \$0.00

(H) TOTAL RETENTION \$102,941.76

(2) DIVIDEND OR RETROACTIVE RATE REFUND

d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR

(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT \$ 0.00

(2) CLAIM RESERVES \$665,616.83

(3) OTHER RESERVES \$0.00

(E) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE \$0.00

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Self-Insured Benefits

Schedule As will not be included in the 5500 for the benefits that were self-insured. Schedule As are only to report fully insured benefits.

We did include the appropriate benefit code(s) for the benefit(s) and checked general assets for funding.

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Self-Insured Benefit

Employee Assistance Program (EAP)

A Schedule A will not be included in the 5500 as the benefit was self-insured. A Schedule A is only to report fully insured benefits.

We did include the appropriate benefit code for the benefit and checked general assets for funding.

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The Summary Annual Report...SAR

 $^{\uparrow 0}$ I have reviewed the SAR.

The Summary Annual Report, also known by its acronym, the SAR, is, generally speaking, a one-page summary of the ERISA Plan's Form 5500 report. ERISA mandates for the SAR to be distributed to Plan Participants within two months from the Form 5500's due date (the SAR is not required to be issued if the plan is 100% self-funded such as a Health FSA plan).

The SAR's purpose is to inform the Plan Participants of the carriers and the policies included within the Form 5500 report. Additionally, funding is noted as well as the financials including the total premium spent and the claim total, if applicable.

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SUMMARY ANNUAL REPORT

For Seton Hall University Welfare Benefit Program

This is a summary of the annual report of the Seton Hall University Welfare Benefit Program, EIN 22-1500645, Plan No. 505, for period 01/01/2023 through 12/31/2023. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Seton Hall University has committed itself to pay certain self-insured Employee Assistance Program, Prescription Drug, and Health Flexible Spending Account claims incurred under the terms of the plan.

Insurance Information

The plan has contracts with Hartford Life and Accident, Cigna Health and Life Insurance Company and Affiliates, Fidelity Security Life Insurance Company, Delta Dental of New Jersey, Inc., Alpha Dental Programs, Inc., and Standard Insurance Company to pay Medical, Dental, Vision, Life Insurance, Long-term Disability, and Accidental Death and Dismemberment claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2023 were \$22,558,427.

Because they are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 12/31/2023, the premiums paid under such "experience-rated" contracts were \$1,449,500 and the total of all benefit claims paid under these contracts during the plan year was \$1,868,422.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

• insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Seton Hall University at 400 S Orange Avenue, South Orange, NJ, 070792646 or by telephone at 973-761-9181.

You also have the legally protected right to examine the annual report at the main office of the plan (Seton Hall University, 400 S Orange Avenue, South Orange, NJ, 070792646) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

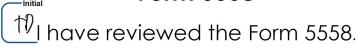
Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL PRA PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)

Form 5558



The following is a copy of the Form 5558. Wrangle has submitted the original to the IRS on the Plan Sponsor's behalf (unless the Plan Sponsor indicated that they had already done so).

The IRS's Form 5558's purpose is to request for an automatic extension for the Form 5500 filing deadline by $2\frac{1}{2}$ months.

This form does not require a signature.

Currently Form 5558 cannot be e-filed; a hard copy is to be mailed. To be accepted and receive the extension, the IRS does require without leniency for the mailing to be postmarked by or on the due date of the Form 5500 filing deadline.

Disclaimer: Wrangle, LLC as well as its employees and affiliates do not offer legal and accounting consultation and services. Information relayed through Wrangle-produced materials serves to provide general information only; whether expressed or implied it is not intended to constitute legal or other advice or opinions on any specific matters and is not intended to replace the advice of a qualified attorney, accountant, or other professional advisor. Wrangle applies its best effort to provide accurate and complete results and provides its service in accordance with the ERISA rules that govern Form 5500 completion. This email may contain information that is confidential. Any use, disclosure, distribution, or duplication by anyone other than an intended recipient is prohibited. This email may include the use of links to a third-party's website, and the use of these links is done at your own discretion and risk.

For Privacy Act and Paperwork Reduction Act Notice, see instructions.

Print Form

5558 Form

(Rev. January 2024)

Department of the Treasury Internal Revenue Service

Application for Extension of Time To File Certain Employee Plan Returns

Go to www.irs.gov/Form5558 for the latest information.

OMB No. 1545-1610

File With IRS Only

Form **5558** (Rev. 1-2024)

Pa	rt I Identification		
A	Name of filer, plan administrator, or plan sponsor (see instructions)	В	Employer identification number (EIN)
	SETON HALL UNIVERSITY		22-1500645
	Number, street, and room or suite no. (If a P.O. box, see instructions.)		
	400 S ORANGE AVENUE		
	City or town, state, and ZIP code		
	SOUTH ORANGE NJ 070792646		
С	Name of plan	D	Three-digit plan number (PN)
	SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM		505
E	Plan year end date		
	12/31/2023		
Pai	Extension of Time To File Form 5500 Series, and/or Form 89	55-	SSA
1	☐ Check this box if you are requesting an extension of time on line 2 to file the in Part I, item C, above.	e fir	st Form 5500 series return/report for the plan listed
2	I request an extension of time until1	5500	series. See instructions.
3	I request an extension of time until / to file Form	8955	i-SSA. See instructions.
	The application is automatically approved to the date shown on line 2 and/or the normal due date of Form 5500 series, and/or Form 8955-SSA for which and/or line 3 (above) is not later than the 15th day of the 3rd month after the no	this	extension is requested; and (b) the date on line 2

Cat. No. 12005T