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

2021

This Form is Open to Public Inspection

Part I Annual Report Identification Information								
For caler								
A This	return/report is for:	a multiemployer plan	ш :	oloyer plan (Filers checking this t mployer information in accordan			ns.)	
		X a single-employer plan	a DFE (specify	')				
B This	return/report is:	the first return/report	the final return	/report				
- 111101	otarryroport io.	an amended return/report	a short plan ye	ear return/report (less than 12 mo	nonths)			
C If the	plan is a collectively-barga	ined plan, check here		• •	Π			
D Chan	k box if filing under:	X Form 5558	automatic exte	nsion	_ □ the DE\	VC program		
D Chec	k box ii iiiiiig under.	special extension (enter description			☐ «10 B1	v o program		
E If this	is a retroactively adopted	plan permitted by SECURE Act section	•		П			
Part II		nation—enter all requested informatio						
1a Nam	ne of plan	FARE BENEFIT PROGRAM				ree-digit plan mber (PN) ▶	505	
021011	TIMEE SHIVE HOLL TWEE	THE SEIVER IT ROOM IN			1c Effe	ective date of pla 16/1966	an	
Mail City	ing address (include room, or town, state or province,	r, if for a single-employer plan) apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code	(if foreign, see instr	uctions)	Nur	2b Employer Identification Number (EIN) 22-1500645		
SETON	HALL UNIVERSITY				2c Plan Sponsor's telephone number 973-761-9181		•	
	RANGE AVENUE ORANGE, NJ 07079-2646				inst	siness code (see ructions)		
Caution	: A penalty for the late or	incomplete filing of this return/repor	t will be assessed	unless reasonable cause is es	stablished			
Under pe	enalties of perjury and othe nts and attachments, as we	r penalties set forth in the instructions, I Ill as the electronic version of this return	declare that I have h/report, and to the b	examined this return/report, incl est of my knowledge and belief,	uding acco it is true, c	ompanying sche correct, and com	dules, iplete.	
SIGN HERE	Filed with authorized/valid	electronic signature.	10/13/2022	TERRI DEMAREST				
HEKE	Signature of plan admir	nistrator	Date	Enter name of individual signi	ng as plan	administrator		
SIGN								
HERE	Signature of employer/p	plan sponsor	Date	Enter name of individual signi	ng as emp	loyer or plan sp	onsor	
SIGN								
HERE			i					

Date

Signature of DFE

Enter name of individual signing as DFE

Form 5500 (2021) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **4d** PN а Sponsor's name Plan Name 5 Total number of participants at the beginning of the plan year 1386 5 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 1367 a(1) Total number of active participants at the beginning of the plan year...... 6a(1) 1362 a(2) Total number of active participants at the end of the plan year 6a(2)22 6b **b** Retired or separated participants receiving benefits....... 0 Other retired or separated participants entitled to future benefits 6c 1384 Subtotal. Add lines 6a(2), 6b, and 6c. 6d Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .. 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: **b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4B 4D 4E 4H 4L 4Q **9a** Plan funding arrangement (check all that apply) **9b** Plan benefit arrangement (check all that apply) (1) Insurance (1) Insurance (2) Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts (3) Trust (3) Trust (4) General assets of the sponsor (4) General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules **b** General Schedules R (Retirement Plan Information) **H** (Financial Information) (1) (1) (2) I (Financial Information - Small Plan) (2) MB (Multiemployer Defined Benefit Plan and Certain Money

X

5 A (Insurance Information)

C (Service Provider Information)

D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

(3)

(4)

(5)

(6)

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

actuary

(3)

	Form 5500 (2021)	Page 3
Part III	Form M-1 Compliance Information (to be completed by welf	are benefit plans)
	plan provides welfare benefits, was the plan subject to the Form M-1 filing require 101-2.)	ments during the plan year? (See instructions and 29 CFR

If "Yes" is checked, complete lines 11b and 11c. 11c Enter the Receipt Confirmation Code for the 2021 Form M-1 annual report. If the plan was not required to file the 2021 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) Receipt Confirmation Code_

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2021

This Form is Open to Public

pursuant to ERISA section 103(a)(2).							Inspection	
For calendar plan year 20:	21 or fiscal plar	year beginning 01/01/2021		and en	ding 12/3	1/2021		
A Name of plan SETON HALL UNIVERSIT	ΓY WELFARE Ε	BENEFIT PROGRAM		B Three	e-digit number (PN	N) •	505	
C Plan sponsor's name a SETON HALL UNIVERSIT		e 2a of Form 5500			oyer Identific 1500645	ation Number (EIN)	
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca HARTFORD LIFE AND AC								
(b) FINI	(c) NAIC	(d) Contract or	(e) Approximate nui			Policy or co	ontract year	
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	(g) To	
06-0838648	70815	681147G	1428		01/01/2021		12/31/2021	
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tota	ll commissions paid. Lis	st in line 3	the agents,	brokers, and o	ther persons in	
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid							
	42446 15959							
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all p	ersons).				
		nd address of the agent, broker,		commiss	ions or fees	were paid		
MERCER HEALTH AND BI	ENEFITS, LLC		YSPHERE CIRCLE 60, IL 60674					
(b) Amount of sales ar	nd base	Fee	s and other commission	s paid				
commissions pa		(c) Amount	(1	d) Purpose	е		(e) Organization code	
	21722						3	
	(a) Name a	nd address of the agent, broker,	or other person to whom	commiss	ions or fees	were paid		
JAMES R NELLIGAN & AS		2338 IM SUITE 2	MOKALEE RD			·		
(b) Amount of sales ar	nd base	Fee:	s and other commission	s paid				
commissions pa		(c) Amount	(d) Purpose				(e) Organization code	
	20724	10362 FE	ES				3	

Page 2 –	1
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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

MERCER HUMAN RESOURCE CONSULTING

4565 PAYSPHERE CIRCLE
CHICAGO, IL 60674

		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
	5597	ADDITIONAL COMPENSATION	3		
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
(a) Nai	ne and address of the agent, broker	, or other person to whom commissions of rees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
()))					
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
commissions paid			0000		
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
commissions palu	,		code		
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization		
commissions paid	(4)	(-)	code		

Part II					
		Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with ea	acn carrier may be treated as a u	ınıt for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		tracts With Allocated Funds:		<u> </u>	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqu	isition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here	→	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate a	ccounts)	
	а		te participation guara		
		(3) guaranteed investment (4) other			
		(b) guaranteed investment (1) guarantee			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
)			
		(C)Total additions		7c(6)	C
	А	(6)Total additions			0
		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	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- /		
		,			
				_ /=\	-
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Pa	art	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 individual	up of employees of th purposes if such conf	tracts are	expe	erience-rated as a un	it. Where co	ntracts cover in	zations(s), dividual
8	Ren	nefit and contract type (check all applicable boxes)							
	a 「		Dental		٦ ٦	Vision		d X Life insur	anco
	L				느				
	е	Temporary disability (accident and sickness) f	Long-term disabili	-		Supplemental unem	ployment	h Prescript	on drug
	i	Stop loss (large deductible)	HMO contract		k 📗	PPO contract		I Indemnity	/ contract
	m	X Other (specify) ▶ACCIDENTAL DEATH AND DIS	SMEMBERMENT						
9 1	Ехре	perience-rated contracts:							
	a I	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium reserv	re	9a(3)					
		(4) Earned ((1) + (2) - (3))					9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1))				
		(2) Increase (decrease) in claim reserves					_		
		(3) Incurred claims (add (1) and (2))					9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on a	n accrual basis)						
		(A) Commissions		9c(1)(/					
		(B) Administrative service or other fees		9c(1)(I					
		(C) Other specific acquisition costs		9c(1)(0					
		(D) Other expenses		9c(1)([•				
		(E) Taxes		9c(1)(E	_				
		(F) Charges for risks or other contingencies							
		(G) Other retention charges		9c(1)(0	i)		T		
		(H) Total retention			_		9c(1)(H)	1	0
		(2) Dividends or retroactive rate refunds. (These ar	nounts were paid in	n cash, or	C	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) A	mount held to provide	benefits a	after	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not i	nclude amount entere	d in line 9	c(2).)	9e		
10	No	Ionexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carr	ier				10a		641678
	b								
	C	retention of the contract or policy, other than reporte	ed in Part I, line 2 abov	e, report	amo	unt	10b		
	Spe	ecify nature of costs.							
Pa	art l	IV Provision of Information	<u> </u>						
		oid the insurance company fail to provide any informati	on necessary to comp	lete Sche	dule	Α?	Yes	X No	
				.510 50116	auic				
ı۷	II (the answer to line 11 is "Yes," specify the information	not provided. 🔻						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

This Form is Open to Public

pursuant to ERISA section 103(a)(2).							Inspection		
For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021		and en	ding 12/31	1/2021			
A Name of plan SETON HALL UNIVERSIT	TY WELFARE I	BENEFIT PROGRAM		B Thre	e-digit number (PN	N) •	505		
C Plan sponsor's name a SETON HALL UNIVERSIT		e 2a of Form 5500			oyer Identification	ation Number (EIN)		
		ning Insurance Contract . Individual contracts grouped as							
1 Coverage Information:									
(a) Name of insurance ca		COMPANY AND AFFILIATES							
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year		
(b) EIN	code	identification number	I hereone covered at end of		(f)	From	(g) To		
59-1031071	67369	3334085	1039		01/01/2021		12/31/2021		
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. Li	st in line 3	the agents,	brokers, and o	ther persons in		
(a) Total	(a) Total amount of commissions paid (b) Total amount of fees paid								
		18					188690		
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).					
		nd address of the agent, broker,		m commiss	ions or fees	were paid			
MERCER HEALTH AND B	ENEFITS, LLC		YSPHERE CIRCLE GO, IL 60674						
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid					
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code		
	18	188690 BE	NEFIT ADVISOR PAYI	MENTS			3		
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid			
			·			·			
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid					
commissions pa		(c) Amount		(d) Purpose			(e) Organization code		
	A 4 NI 41	4 1 4 4 7 7 -					1 1 A /E EEOO\		

(a) Nar	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Face and other consistence and d	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broke	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
(a) Nar	me and address of the agent, broke	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
(a) Nar	me and address of the agent, broke	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

Part II					
		Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with ea	acn carrier may be treated as a u	ınıt for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		tracts With Allocated Funds:		<u> </u>	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqu	isition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here	→	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate a	ccounts)	
	а		te participation guara		
		(3) guaranteed investment (4) other			
		(b) guaranteed investment (1) guarantee			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
)			
		(C)Total additions		7c(6)	C
	А	(6)Total additions			0
		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	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- /		
		,			
				_ /=\	-
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Pa	art I	II	Welfare Benefit Contract Informal If more than one contract covers the same the information may be combined for report	group of employees of the	e same er	nplo	yer(s) or members of erience-rated as a unit	the same e	mploye	ee organizations(s), s cover individual
			employees, the entire group of such individ							
8	Bene	efit ar	nd contract type (check all applicable boxes)							
	a >	He	alth (other than dental or vision)	b Dental		c 🗌	Vision		d	Life insurance
	еГ	Те	mporary disability (accident and sickness)	f Long-term disabili	ty	gΠ	Supplemental unemp	oloyment	h∏	Prescription drug
	iΓ	Sto	op loss (large deductible)	j HMO contract		k 🗌	PPO contract		IX	Indemnity contract
	m	_	her (specify)	- 🗀						-
	∟		(epeciny)							
9 1	xpe	rienc	ce-rated contracts:							
	a F	remi	iums: (1) Amount received		9a(1)					
			ncrease (decrease) in amount due but unpaid							
			ncrease (decrease) in unearned premium res		``	-				
			arned ((1) + (2) - (3))					9a(4)		0
	_		efit charges (1) Claims paid					, ,		
			ncrease (decrease) in claim reserves							
		` '	ncurred claims (add (1) and (2))					9b(3)		0
		. ,	laims charged					9b(4)		
		` '	nainder of premium: (1) Retention charges (o							
			(A) Commissions	•	9c(1)(A	4)				
		,	(B) Administrative service or other fees		9c(1)(E					
		Ò	(C) Other specific acquisition costs		9c(1)(0					
			(D) Other expenses		9c(1)([))				
		((E) Taxes		9c(1)(E	Ξ)				
		((F) Charges for risks or other contingencies		9c(1)(F	-)				
		((G) Other retention charges		9c(1)(0	3)				
		((H) Total retention					9c(1)(H))	0
		(2)	Dividends or retroactive rate refunds. (These	amounts were paid ir	cash, or	C	credited.)	9c(2)		
	d		us of policyholder reserves at end of year: (1			_		9d(1)		
			Claim reserves	•				9d(2)		
		(3) C	Other reserves					9d(3)		
	е	Divid	dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9	c(2).)	9e		
10	No	nexp	erience-rated contracts:							
	а	Tota	Il premiums or subscription charges paid to c	arrier				10a		18794289
	b	If the	e carrier, service, or other organization incurr	ed any specific costs in c	onnection	with	h the acquisition or			
		reter	ntion of the contract or policy, other than repo					10b		
	O po.	ony 11	ature of costs.							
Pa	nrt I	v 「	Provision of Information							
				ation necessary to espen	loto Sobo	dula	л2 П	Yes	X No)
			insurance company fail to provide any inform		ete Sche	uuie	Α (169	^ INC	,
12	if th	ne an	swer 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

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 20	For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021						
A Name of plan SETON HALL UNIVERSIT	TY WELFARE	BENEFIT PROGRAM					
				pian	number (PN)		
C Plan sponsor's name a	s shown on lir	ne 2a of Form 5500		D Emplo	oyer Identification Numb	er (FIN)	
SETON HALL UNIVERSIT		24 011 01111 0000			1500645	or (E114)	
Part I Informat	ion Conce	rning Insurance Contra	ct Coverage Fees	and Con	nmissions Provide ir	oformation for each contract	
		A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
FIDELITY SECURITY LIFE	INSURANCE	COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate n		Policy o	r contract year	
(b) EIN	code	identification number	·	persons covered at end of policy or contract year		(g) To	
43-0949844	71870	1008322	2319		01/01/2021	12/31/2021	
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, an	d other persons in	
	amount of com	missions paid		(b) To	otal amount of fees paid		
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid		
		F	ees and other commissio	ne naid			
(b) Amount of sales ar commissions pa		(c) Amount	ces and other commission	(d) Purpos	e	(e) Organization code	
•							
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	<u>.</u>	
	(4)	, , , , , , , , , , , , , , , , , , ,	· , · · · · · , · · · · · · ·				
(b) Amount of sales ar	(b) Amount of sales and base Fees and other commissions paid						
commissions pa	id	(c) Amount		(d) Purpos	e	(e) Organization code	

(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Face and other consistence and d	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broke	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
(a) Nar	me and address of the agent, broke	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
(a) Nar	me and address of the agent, broke	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

F	Part		Short control of 199		
		Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with ea	acn carrier may be treated as a u	ınıt for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		tracts With Allocated Funds:		<u> </u>	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqu	isition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here	→	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate a	ccounts)	
	а		te participation guara		
		(3) guaranteed investment (4) other			
		(b) guaranteed investment (1) guarantee			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
)			
		(C)Total additions		7c(6)	C
	А	(6)Total additions			0
		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	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- / 1		
		,			
				_ /=\	-
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

P	art III Welfare Benefit Contract Informati	on					
•	If more than one contract covers the same gro		e same emplo	oyer(s) or members of	the same en	nployee organizat	ions(s),
	the information may be combined for reporting						^r iduaÌ
	employees, the entire group of such individual	contracts with each ca	arrier may be	treated as a unit for p	urposes of th	nis report.	
8	Benefit and contract type (check all applicable boxes)						
	a Health (other than dental or vision)	Dental	CX	Vision		d Life insuran	ce
		Long-term disabili		Supplemental unem	nlovment	h ☐ Prescription	
		=		4	іріоўпіспі		-
	i Stop loss (large deductible) j	HMO contract	K_	PPO contract		I Indemnity c	ontract
	m ☐ Other (specify) ▶						
9	Experience-rated contracts:						
	a Premiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpaid		9a(2)				
	(3) Increase (decrease) in unearned premium reserv		9a(3)				
	(4) Earned ((1) + (2) - (3))				. 9a(4)		0
	b Benefit charges (1) Claims paid				, , ,		
	(2) Increase (decrease) in claim reserves						
	(3) Incurred claims (add (1) and (2))				9b(3)		0
	(4) Claims charged				9b(4)		
	C Remainder of premium: (1) Retention charges (on a						
	(A) Commissions	ŕ	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)			_	
			o (1)(=)			_	
	(F) Charges for risks or other contingencies						
	(G) Other retention charges				0c/1\/U\		0
	(H) Total retention				9c(1)(H)		
	(2) Dividends or retroactive rate refunds. (These ar				9c(2)		
	d Status of policyholder reserves at end of year: (1) A	•			9d(1)		
	(2) Claim reserves				9d(2)		
	(3) Other reserves				9d(3)		
	e Dividends or retroactive rate refunds due. (Do not i	nclude amount entered	d in line 9c(2)	.)	9e		
10	Nonexperience-rated contracts:						
	a Total premiums or subscription charges paid to carr	ier			10a		98718
	b If the carrier, service, or other organization incurred	any specific costs in c	onnection wit	h the acquisition or			
	retention of the contract or policy, other than reporte	ed in Part I, line 2 abov	e, report amo	ount	10b		
	Specify nature of costs.						
_							
	art IV Provision of Information			-	, , , , , , , , , , , , , , , , , , ,		
11	Did the insurance company fail to provide any informati	on necessary to comp	ete Schedule	A?	Yes	X No	
12	If the answer to line 11 is "Yes," specify the information	not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2021

						rm is Open to Public Inspection		
For calendar plan year 20	21 or fiscal pla	an year beginning 01/01/2021		and en	ding 12/31	/2021		
A Name of plan SETON HALL UNIVERSIT	TY WELFARE	BENEFIT PROGRAM			e-digit number (PN) •	505	
C Plan sponsor's name a SETON HALL UNIVERSIT		ne 2a of Form 5500			oyer Identifica 1500645	tion 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 DELTA DENTAL OF NEW								
(h) []N	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or o	ontract year	
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To	
22-1896118	55085	07742	1902	1902 01/01/2021			12/31/2021	
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, b	rokers, and o	other persons in	
(a) Total amount of commissions paid				(b) To	otal amount o	f fees paid		
35491 0						0		
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).				
		and address of the agent, broke	·	m commiss	ions or fees v	were paid		
MERCER HEALTH & BEN	EFITS LLC		PAYSPHERE CIRCLE AGO, IL 60674					
(b) Amount of sales a	nd hase	F	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code	
	35491						3	
	(a) Name	and address of the agent, broke	er or other person to who	m commissi	ions or fees v	were naid		
	(4)	a aaa 0. 0. 1 ago, 2.0	., c. ca.c. porce. to			o.o paid		
(b) Amount of sales a	nd base	F	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code	

(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Face and other consistence and d	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broke	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
(a) Nar	me and address of the agent, broke	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
(a) Nar	me and address of the agent, broke	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

F	Part		Short control of 199		
		Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with ea	acn carrier may be treated as a u	ınıt for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		tracts With Allocated Funds:		<u> </u>	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqu	isition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here	→	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate a	ccounts)	
	а		te participation guara		
		(3) guaranteed investment (4) other			
		(b) guaranteed investment (1) guarantee			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
)			
		(C)Total additions		7c(6)	C
	А	(6)Total additions			0
		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	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- / 1		
		,			
				_ /=\	-
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Р	art III	Welfare Benefit Contract Informa	ation						
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ing purposes if such cont	racts are	expe	erience-rated as a unit	. Where co	ontracts cove	
8	Benefit	t and contract type (check all applicable boxes)				<u> </u>	•	•	
_	_	Health (other than dental or vision)	b X Dental		с∏	Vision		d ☐ Life ii	nsurance
			=		ᆜ		-1	브	
	느	Temporary disability (accident and sickness)	f Long-term disabili	-	g ∐ -		bioyment	=	cription drug
	' <u>U</u>	Stop loss (large deductible)	j HMO contract		K \square	PPO contract		I Inden	nnity contract
	m	Other (specify)							
9	Experie	ence-rated contracts:							
		emiums: (1) Amount received		9a(1)			990002	2	
) Increase (decrease) in amount due but unpaid			_			_	
) Increase (decrease) in unearned premium res					0-(4)		000000
) Earned ((1) + (2) - (3))					9a(4)		990002
		enefit charges (1) Claims paid		(-)			770824	_	
	` ') Increase (decrease) in claim reserves					13589	,	784413
) Incurred claims (add (1) and (2))					9b(3) 9b(4)		784414
	` ') Claims chargedemainder of premium: (1) Retention charges (c				•••••	3D(4)		70441-
	CK	(A) Commissions		9c(1)(A	۸۱		35491		
		(B) Administrative service or other fees		9c(1)(E			98334		
		(C) Other specific acquisition costs		9c(1)(0			0000	_	
		(D) Other expenses		9c(1)([_				
		(E) Taxes		9c(1)(E					
		(F) Charges for risks or other contingencies .		9c(1)(F	_		12870)	
		(G) Other retention charges		9c(1)(0	G)				
		(H) Total retention		-			9c(1)(H))	146695
	(2	2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	П	credited.)	9c(2)		
		tatus of policyholder reserves at end of year: (1	_		_		9d(1)		
	(2	2) Claim reserves					9d(2)		61024
	(3	B) Other reserves					9d(3)		
	e D	ividends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9	c(2).)	9e		
10	None	experience-rated contracts:							
	a To	otal premiums or subscription charges paid to c	arrier				10a		(
	re	the carrier, service, or other organization incurretention of the contract or policy, other than repe					10b		
	Specin	y nature of costs.							
Р	art IV	Provision of Information							
11	Did th	ne insurance company fail to provide any inform	ation necessary to comp	lete Sche	dule	A?	Yes	X No	
12	If the	answer 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

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

This Form is Open to Public

For calendar plan year 202	21 or fiscal plar	n year beginning 01/01/2021		and er	nding 12/31/2021			
A Name of plan SETON HALL UNIVERSIT	TY WELFARE I	BENEFIT PROGRAM			ee-digit n number (PN)	505		
C Plan sponsor's name a SETON HALL UNIVERSIT		e 2a of Form 5500		D Employer Identification Number (EIN) 22-1500645				
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 ALPHA DENTAL PROGRA								
(I.) FINI	(c) NAIC	(d) Contract or	(e) Approximate n		Policy of	or contract year		
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To		
74-2447512	95163	78998	361		01/01/2021	12/31/2021		
2 Insurance fee and communication descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, ar	nd other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid					<u> </u>			
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	I es as needed to report all	persons).				
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid			
(b) Amount of sales ar	nd base	F	ees and other commissio	•				
commissions pai	id	(c) Amount		(d) Purpose		(e) Organization code		
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid			
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid				
commissions pai		(c) Amount	(d) Purpose			(e) Organization code		

(a) Nar	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Face and other consistence and d	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broke	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
(a) Nar	me and address of the agent, broke	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
(a) Nar	me and address of the agent, broke	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

F	Part		Short control of 199		
		Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with ea	acn carrier may be treated as a u	ınıt for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		tracts With Allocated Funds:		<u> </u>	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqu	isition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here	→	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate a	ccounts)	
	а		te participation guara		
		(3) guaranteed investment (4) other			
		(b) guaranteed investment (1) guarantee			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
)			
		(C)Total additions		7c(6)	C
	А	(6)Total additions			0
		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	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- / 1		
		,			
				- /->	-
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Pa	art I	II	Welfare Benefit Contract Informa	ation					
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are expe	erience-rated as a un	it. Where co	ontracts co	over individual
8	Bene	efit ar	nd contract type (check all applicable boxes)			·	<u> </u>		
	a 「	_	alth (other than dental or vision)	b X Dental	c۲	Vision		d∏ Life	e insurance
	_ _	_			<u> </u>	1			
	e [_		f Long-term disabili		Supplemental unem	ployment		escription drug
	i [Sto	op loss (large deductible)	j HMO contract	k _	PPO contract		I Ind	lemnity contract
	m	Ot	her (specify)						
9 E	Expe	erienc	e-rated contracts:						
	a F	Prem	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	l	9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		0
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)		0
			laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis)					
		(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				T		
		,	H) Total retention				9c(1)(H)	0
		(2)	Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or 🔲 (credited.)	9c(2)		
	d	Stat	us of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)		
		(2)	Claim reserves				9d(2)		
		(3)	Other reserves				9d(3)		
			dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2) .	.)	9e		
10	No	nexp	erience-rated contracts:						
	а	Tota	I premiums or subscription charges paid to c	arrier			10a		49713
	b		e carrier, service, or other organization incurr						
	O	reter	ntion of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	ount	10b		
	Spe	city n	ature of costs.						
Dr	art I	V	Provision of Information						
							Vaa	N	
			insurance company fail to provide any inform		lete Schedule	A?	Yes	X No	
12	If th	ne an	swer to line 11 is "Yes," specify the informati	on not provided.					

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

2021

This Form is Open to Public Inspection

Part I Annual Report	Identification Inform	ation				
For calendar plan year 2021 or fis	scal plan year beginning	01/01/2021	and ending	12/31/2	021	
A This return/report is for:	a multiemployer pla	1 [a multiple-employer plan (Filers che participating employer information)	-		ns.)
B This return/report is:	a single-employer p	<u>_</u>	a DFE (specify) the final return/report			
This return/report is.	an amended return/	<u></u>	a short plan year return/report (less	s than 12 mon	ths)	
C If the plan is a collectively-bar	gained plan, check here				▶ 🗌	
D Check box if filing under:	X Form 5558		automatic extension		the DFVC program	
_	special extension (en					
E If this is a retroactively adopte	d plan permitted by SECUF	RE Act section 201	1, check here			
Part II Basic Plan Info	rmation—enter all reque	sted information				
1a Name of plan SETON HALL UNIVERSITY WELFARE BENEFIT PROGRAM					1b Three-digit plan number (PN) ▶	505
				,	1c Effective date of plan 09/16/1966	
2a Plan sponsor's name (emplo Mailing address (include roor City or town, state or provinc	m, apt., suite no. and street	, or P.O. Box)	foreign, see instructions)		2b Employer Identification Number (EIN) 22-1500645	tion
SETON HALL UNIVERSITY					2c Plan Sponsor's telephone number 973-761-9181	
400 S ORANGE AVENUE					2d Business code (see instructions) 611000	9
SOUTH ORANGE	NJ 07079-2646					

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

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

	•	' '	
SIGN HERE	Gerri Demarest	10/13/2022	Terri Demarest
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Lerri Demarest	10/13/2022	Terri Demarest
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN			
HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

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 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: Sponsor's name Plan Name 	numl 4b EIN	nistrator's telephone ber	
enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name			
enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name			
·	4d DV	4b EIN	
	4d PN		
5 Total number of participants at the beginning of the plan year	5	1,386	
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		1,000	
a(1) Total number of active participants at the beginning of the plan year	6a(1)	1,367	
a(2) Total number of active participants at the end of the plan year	6a(2)	1,362	
b Retired or separated participants receiving benefits	6b	22	
C Other retired or separated participants entitled to future benefits	6c	0	
d Subtotal. Add lines 6a(2), 6b, and 6c.	6d	1,384	
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e		
f Total. Add lines 6d and 6e.	6f		
Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g		
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested			
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7		
 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes 4A 4B 4D 4E 4H 4L 4Q 			
Plan funding arrangement (check all that apply) (1)	3) insurance contracts		
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number	oer attache	ed. (See instructions)	
a Pension Schedules b General Schedules			
(1) R (Retirement Plan Information) (1) H (Financial Inform	,	and Diam	
(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan (3) 5 A (Insurance Information)			
(3) SB (Single-Employer Defined Benefit Plan Actuarial (5) D (DFE/Participati		,	
Information) - signed by the plan actuary (6) G (Financial Trans	saction Sch	nedules)	