

<b>Form 5500</b> Department of the Treasury Internal Revenue Service <hr/> Department of Labor Employee Benefits Security Administration <hr/> Pension Benefit Guaranty Corporation	<b>AalRetRep</b> 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 <hr/> <div style="font-size: 24pt; font-weight: bold; text-align: center;">2022</div> <hr/> This Form is Open to Public Inspection
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<b>Part I</b>	<b>AalRep</b>	For calendar plan year 2022 or fiscal plan year beginning <b>01/01/2022</b> and ending <b>12/31/2022</b>	
A This return/report is for:		<input type="checkbox"/> a multiemployer plan	<input type="checkbox"/> a multiple-employer plan (filers checking this box must attach a list of participating employer information in accordance with the form instr.)
B This return/report is:		<input checked="" type="checkbox"/> a single-employer plan	<input type="checkbox"/> a DFE (specify) _____
		<input type="checkbox"/> the first return/report	<input type="checkbox"/> the final return/report
		<input type="checkbox"/> an amended return/report	<input type="checkbox"/> a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here		<input type="checkbox"/>	
D Check box if filing under:		<input type="checkbox"/> Form 5558	<input type="checkbox"/> automatic extension
		<input type="checkbox"/> special extension (enter description)	<input type="checkbox"/> the DFVC program
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here		<input type="checkbox"/>	

<b>Part II</b>	<b>Basic Information</b>	- enter all requested information	
1a Name of plan <b>ZETA ASSOCIATES INCORPORATED INDIVIDUAL BENEFIT ACCOUNT</b>		1b Three-digit plan number (PN)	<b>501</b>
		1c Effective date of plan <b>06/01/1984</b>	
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) <b>ZETA ASSOCIATES INCORPORATED</b>		2b Employer Identification Number (EIN) <b>54-1279046</b>	
		2c Plan Sponsor's telephone number <b>703-385-7050</b>	
<b>10302 EATON PLACE SUITE 500 FAIRFAX VA 22030</b>		2d Business code (see instructions) <b>541700</b>	

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		<b>04/24/2023</b>	<b>SUE SUK</b>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		<b>04/24/2023</b>	<b>SUE SUK</b>
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN
	3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN
	4d PN

5 Total number of participants at the beginning of the plan year	5
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).	
a (1) Total number of active participants at the beginning of the plan year ~ ~ ~ ~ ~	6a(1)
a (2) Total number of active participants at the end of the plan year ~ ~ ~ ~ ~	6a(2)
b Retired or separated participants receiving benefits ~ ~ ~ ~ ~	6b
c Other retired or separated participants entitled to future benefits ~ ~ ~ ~ ~	6c
d Subtotal. Add lines 6a(2), 6b, and 6c ~ ~ ~ ~ ~	6d
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits ~ ~ ~ ~ ~	6e
f Total. Add lines 6d and 6e ~ ~ ~ ~ ~	6f
g 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	6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7

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

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

Plan funding arrangement (check all that apply)	Plan benefit arrangement (check all that apply)
(1) <input type="checkbox"/> Insurance	(1) <input type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input type="checkbox"/> Trust	(3) <input type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> General assets of the sponsor

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

<b>Pension Schedules</b> (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	<b>General Schedules</b> (1) <input type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information - Small Plan) (3) <input type="checkbox"/> A (Insurance Information) (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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<b>Part III</b>	<b>Form M-1 Corp</b>
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11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ~~~~~  Yes  No  
 If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)  Yes  No

11c Enter the Receipt Confirmation Code for the 2022 Form M-1 annual report. If the plan was not required to file the 2022 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	This schedule is required to be filed under section 104 of the    File as an attachment to Form 5500.	OMB No. 1210-0110  This Form is Open to Public Inspection
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For calendar plan year 2022 or fiscal plan year beginning	and ending	

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(a)

(b)	(c)	(d)	(e)	(f)	(g)

(a)	(b)
(a)	

(b)		(e)
	(c)	(d)
(a)		

(b)		(e)
	(c)	(d)

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<b>Part I</b>	<b>Contract Allocation</b> Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates |

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 connection with the acquisition or retention of the contract or policy, enter amount ~ ~ ~ ~ ~ Specify nature of costs	6d	

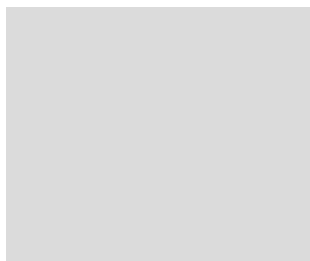
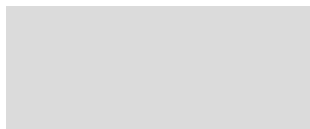
e Type of contract: (1)  individual policies      (2)  group deferred annuity  
(3)  other (specify) |

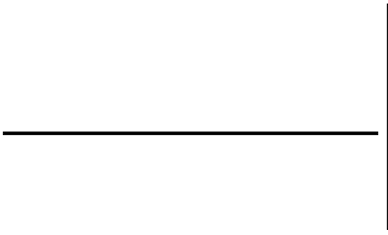
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1)  deposit administration      (2)  immediate participation guarantee  
(3)  guaranteed investment      (4)  other |

<b>b</b> Balance at the end of the previous year		<b>7b</b>	
<b>c</b> 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)		
(6) Total additions ~ ~ ~ ~ ~	7c(6)	0	
<b>d</b> Total of balance and additions (add lines 7b and 7c(6))		<b>7d</b>	
<b>e</b> 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 ~ ~ ~ ~ ~	7e(5)	0	
<b>f</b> Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	







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<b>Part I</b>	<b>Contract Allocation</b> Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates |

b Premiums paid to carrier ~ ~ ~ ~ ~ 

6b	
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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 connection with the acquisition or retention of the contract or policy, enter amount ~ ~ ~ ~ ~ 

6d	
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Specify nature of costs |

e Type of contract: (1)  individual policies      (2)  group deferred annuity  
(3)  other (specify) |

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1)  deposit administration      (2)  immediate participation guarantee  
(3)  guaranteed investment      (4)  other |

b Balance at the end of the previous year		7b	
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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)		

(6) Total additions ~ ~ ~ ~ ~	7c(6)		0
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d Total of balance and additions (add lines 7b and 7c(6))		7d	
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e 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 ~ ~ ~ ~ ~	7e(5)		0
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f Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	
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**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.

- 8 Benefit and contract type (check all applicable boxes)
- |   |   |  |   |
|---|---|--|---|
| a <input type="checkbox"/> Health (other than dental or vision)                     | b <input type="checkbox"/> Dental               | c <input type="checkbox"/> Vision                    | d <input type="checkbox"/> Life insurance     |
| e <input type="checkbox"/> Temporary disability (accident and sickness)             | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug  |
| i <input type="checkbox"/> Stop loss (large deductible)                             | j <input type="checkbox"/> HMO contract         | k <input type="checkbox"/> PPO contract              | l <input type="checkbox"/> Indemnity contract |
| m <input checked="" type="checkbox"/> Other (specify)   <b>STATUTORY DISABILITY</b> |   |  |   |

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 reserve ~ ~ ~ ~ ~	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	
b Benefit charges (1) Claims paid ~ ~ ~ ~ ~	9b(1)		
(2) Increase (decrease) in claim reserves ~ ~ ~ ~ ~	9b(2)		
(3) Incurred claims (add (1) and (2)) ~ ~ ~ ~ ~		9b(3)	
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions ~ ~ ~ ~ ~	9c(1)(A)		
(B) Administrative service or other fees ~ ~ ~ ~ ~	9c(1)(B)		
(C) Other specific acquisition costs ~ ~ ~ ~ ~	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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)	
d Status 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)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier ~ ~ ~ ~ ~	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount ~ ~ ~ ~ ~	10b	

Specify nature of costs.

**Part IV** **Portability Information**

- 11 Did the insurance company fail to provide any information necessary to complete Schedule A?  Yes  No
- 12 If the answer to line 11 is "Yes," specify the information not provided. |



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<b>Part I</b>	<b>Contract Allocation</b> Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates |

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 connection with the acquisition or retention of the contract or policy, enter amount ~ ~ ~ ~ ~ Specify nature of costs	6d	

e Type of contract: (1)  individual policies      (2)  group deferred annuity  
(3)  other (specify) |

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1)  deposit administration      (2)  immediate participation guarantee  
(3)  guaranteed investment      (4)  other |

b Balance at the end of the previous year		7b	
c Additions: (1) Contributions deposited during the year ~ ~ ~ ~ ~ (2) Dividends and credits ~ ~ ~ ~ ~ (3) Interest credited during the year ~ ~ ~ ~ ~ (4) Transferred from separate account ~ ~ ~ ~ ~ (5) Other (specify below) ~ ~ ~ ~ ~ 	7c(1)		
	7c(2)		
	7c(3)		
	7c(4)		
	7c(5)		
(6) Total additions ~ ~ ~ ~ ~		7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))		7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year ~ ~ (2) Administration charge made by carrier ~ ~ ~ ~ ~ (3) Transferred to separate account ~ ~ ~ ~ ~ (4) Other (specify below) ~ ~ ~ ~ ~ 	7e(1)		
	7e(2)		
	7e(3)		
	7e(4)		
(5) Total deductions ~ ~ ~ ~ ~		7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

**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.

- 8 Benefit and contract type (check all applicable boxes)
- |  |   |  |   |
|--|---|--|---|
| a <input checked="" type="checkbox"/> Health (other than dental or vision)           | b <input type="checkbox"/> Dental               | c <input type="checkbox"/> Vision                    | d <input type="checkbox"/> Life insurance     |
| e <input type="checkbox"/> Temporary disability (accident and sickness)              | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug  |
| i <input type="checkbox"/> Stop loss (large deductible)                              | j <input type="checkbox"/> HMO contract         | k <input type="checkbox"/> PPO contract              | l <input type="checkbox"/> Indemnity contract |
| m <input checked="" type="checkbox"/> Other (specify)   <b>SHORT-TERM DISABILITY</b> |   |  |   |

9 Experience-rated contracts:

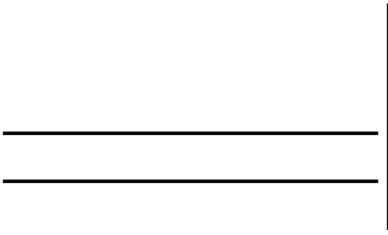
a Premiums: (1) Amount received ~ ~ ~ ~ ~	9a(1)		
(2) Increase (decrease) in amount due but unpaid ~ ~ ~ ~ ~	9a(2)		
(3) Increase (decrease) in unearned premium reserve ~ ~ ~ ~ ~	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	
b Benefit charges (1) Claims paid ~ ~ ~ ~ ~	9b(1)		
(2) Increase (decrease) in claim reserves ~ ~ ~ ~ ~	9b(2)		
(3) Incurred claims (add (1) and (2)) ~ ~ ~ ~ ~		9b(3)	
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions ~ ~ ~ ~ ~	9c(1)(A)		
(B) Administrative service or other fees ~ ~ ~ ~ ~	9c(1)(B)		
(C) Other specific acquisition costs ~ ~ ~ ~ ~	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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)	
d Status 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)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier ~ ~ ~ ~ ~	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount ~ ~ ~ ~ ~	10b	
Specify nature of costs.		

**Part IV** **Portability Information**

- 11 Did the insurance company fail to provide any information necessary to complete Schedule A?  Yes  No
- 12 If the answer to line 11 is "Yes," specify the information not provided. |





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<b>Part I</b>	<b>Contract Allocation</b> Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates |

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 connection with the acquisition or retention of the contract or policy, enter amount ~ ~ ~ ~ ~ Specify nature of costs	6d	

e Type of contract: (1)  individual policies      (2)  group deferred annuity  
(3)  other (specify) |

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here |

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1)  deposit administration      (2)  immediate participation guarantee  
(3)  guaranteed investment      (4)  other |

<b>b</b> Balance at the end of the previous year		<b>7b</b>	
<b>c</b> 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)		
(6) Total additions ~ ~ ~ ~ ~	7c(6)	0	
<b>d</b> Total of balance and additions (add lines 7b and 7c(6))		<b>7d</b>	
<b>e</b> 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 ~ ~ ~ ~ ~	7e(5)	0	
<b>f</b> Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	

**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.

- 8 Benefit and contract type (check all applicable boxes)
- |   |   |  |  |
|---|---|--|--|
| a <input type="checkbox"/> Health (other than dental or vision)         | b <input type="checkbox"/> Dental               | c <input type="checkbox"/> Vision                    | d <input checked="" type="checkbox"/> Life insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug         |
| i <input type="checkbox"/> Stop loss (large deductible)                 | j <input type="checkbox"/> HMO contract         | k <input type="checkbox"/> PPO contract              | l <input type="checkbox"/> Indemnity contract        |
| m <input type="checkbox"/> 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 reserve ~ ~ ~ ~ ~	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	
b Benefit charges (1) Claims paid ~ ~ ~ ~ ~	9b(1)		
(2) Increase (decrease) in claim reserves ~ ~ ~ ~ ~	9b(2)		
(3) Incurred claims (add (1) and (2)) ~ ~ ~ ~ ~		9b(3)	
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions ~ ~ ~ ~ ~	9c(1)(A)		
(B) Administrative service or other fees ~ ~ ~ ~ ~	9c(1)(B)		
(C) Other specific acquisition costs ~ ~ ~ ~ ~	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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)	
d Status 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)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier ~ ~ ~ ~ ~	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount ~ ~ ~ ~ ~	10b	
Specify nature of costs.		

**Part IV** **Portability Information**

- 11 Did the insurance company fail to provide any information necessary to complete Schedule A?  Yes  No
- 12 If the answer to line 11 is "Yes," specify the information not provided. |

<b>SCHEDULE A</b> <b>(Form 5500)</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	<b>Insurance Information</b>  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  <b>2022</b>  This Form is Open to Public Inspection
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For calendar plan year 2022 or fiscal plan year beginning **01/01/2022** and ending **12/31/2022**

<b>A</b> Name of plan <b>ZETA ASSOCIATES INCORPORATED</b>	<b>B</b> Three-digit plan number (PN)	<b>501</b>
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<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>ZETA ASSOCIATES INCORPORATED</b>	<b>D</b> Employer Identification Number (EIN) <b>54-1279046</b>
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<b>Part I</b>	<b>Information concerning each contract coverage, Fees and Commissions</b> 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.	
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**1 Coverage Information:**

(a) Name of insurance carrier  
**LIFE INSURANCE COMPANY OF NORTH AMERICA**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-1503749	65498	OK965514		01/01/2022	12/31/2022

**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
483	48

**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  
**MCGRIFF INSURANCE SERVICES, INC.**  
**P.O. BOX 896620**  
**CHARLOTTE NC 28289**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
483	48		

(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	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a)

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a)

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

<b>Part I</b>	<b>Contract Allocation</b> Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates |

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 connection with the acquisition or retention of the contract or policy, enter amount ~ ~ ~ ~ ~ Specify nature of costs	6d	

e Type of contract: (1)  individual policies      (2)  group deferred annuity  
(3)  other (specify) |

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here |

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1)  deposit administration      (2)  immediate participation guarantee  
(3)  guaranteed investment      (4)  other |

b Balance at the end of the previous year		7b	
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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)		

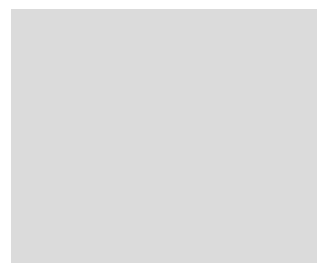
(6) Total additions ~ ~ ~ ~ ~		7c(6)	0
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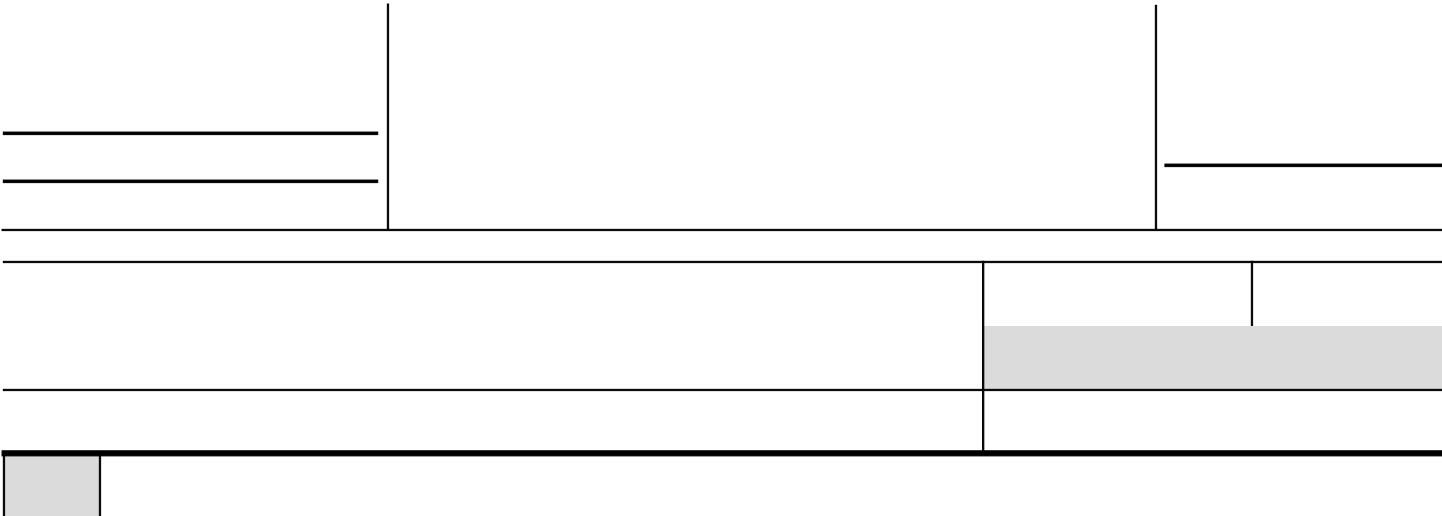
d Total of balance and additions (add lines 7b and 7c(6))		7d	
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e Deductions:			
(1) Disbursed from fund to pay benefits or purchase annuities during year ~ ~	7e(1)		
(2) Administration charge made by carrier ~ ~ ~ ~ ~	7e(2)		
(3) Transferred to separate account ~ ~ ~ ~ ~	7e(3)		
(4) Other (specify below) ~ ~ ~ ~ ~ 	7e(4)		

(5) Total deductions ~ ~ ~ ~ ~		7e(5)	0
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f Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	
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<b>Part I</b>	<b>Contract Allocation</b> Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates |

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 connection with the acquisition or retention of the contract or policy, enter amount ~ ~ ~ ~ ~ Specify nature of costs	6d	

e Type of contract: (1)  individual policies      (2)  group deferred annuity  
(3)  other (specify) |

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1)  deposit administration      (2)  immediate participation guarantee  
(3)  guaranteed investment      (4)  other |

<b>b</b> Balance at the end of the previous year		<b>7b</b>	
<b>c</b> 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)		
(6) Total additions ~ ~ ~ ~ ~	7c(6)	0	
<b>d</b> Total of balance and additions (add lines 7b and 7c(6))		<b>7d</b>	
<b>e</b> 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 ~ ~ ~ ~ ~	7e(5)	0	
<b>f</b> Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	

**Part III** **Welfare Benefit Contract**  
 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.

- 8 Benefit and contract type (check all applicable boxes)
- |   |  |  |   |
|---|--|--|---|
| a <input type="checkbox"/> Health (other than dental or vision)         | b <input type="checkbox"/> Dental                          | c <input type="checkbox"/> Vision                    | d <input type="checkbox"/> Life insurance     |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input checked="" type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug  |
| i <input type="checkbox"/> Stop loss (large deductible)                 | j <input type="checkbox"/> HMO contract                    | k <input type="checkbox"/> PPO contract              | l <input type="checkbox"/> Indemnity contract |
| m <input type="checkbox"/> 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 reserve ~ ~ ~ ~ ~	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	
b Benefit charges (1) Claims paid ~ ~ ~ ~ ~	9b(1)		
(2) Increase (decrease) in claim reserves ~ ~ ~ ~ ~	9b(2)		
(3) Incurred claims (add (1) and (2)) ~ ~ ~ ~ ~		9b(3)	
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions ~ ~ ~ ~ ~	9c(1)(A)		
(B) Administrative service or other fees ~ ~ ~ ~ ~	9c(1)(B)		
(C) Other specific acquisition costs ~ ~ ~ ~ ~	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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)	
d Status 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)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier ~ ~ ~ ~ ~	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount ~ ~ ~ ~ ~	10b	
Specify nature of costs.		

**Part IV** **Portability**

- 11 Did the insurance company fail to provide any information necessary to complete Schedule A?  Yes  No
- 12 If the answer to line 11 is "Yes," specify the information not provided. |

Department of the Treasury Internal Revenue Service	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
Department of Labor Employee Benefits Security Administration		
Pension Benefit Guaranty Corporation		This Form is Open to Public Inspection.

For calendar plan year 2022 or fiscal plan year beginning		and ending	
Name of plan	Three-digit plan number (PN)		
Plan sponsor's name as shown on line 2a of Form 5500	Employer Identification Number (EIN)		

You must complete this Part, in accordance with the instructions, to report the information required for each person who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received only eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions) –  Yes  No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers

(b)

(b)

(b)

(b)

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**2. Director or Other Service Provider Receiving Direct or Indirect Compensation**

Except for those persons for whom

you answered "Yes" to line 1a on page 1, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions) **SEE STATEMENT 1**  
**CIGNA HEALTH & LIFE INSURANCE CO 59-1031071**

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 38 50	PROVIDES CLAIM & SERVICES	0.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

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

(a) Enter name and EIN or address (see instructions)

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

**Pat Seice Poiderfontor (cont'd)**

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

