Form 5500	Annual Return/Report of Employee Benefit Plan			OMB Nos. 12	210-0110
Department of the Treasury Internal Revenue Service	and 4065 of the Employee Retirement	employee benefit plans under sections 104 nt Income Security Act of 1974 (ERISA) and		12	
Department of Labor Employee Benefits Security	► Complete all en	(a) of the Internal Revenue Code (the Code). htries in accordance with		2014	
Administration Pension Benefit Guaranty Corporation	the instruction	ns to the Form 5500.	This	Form is Open to Pu Inspection	ıblic
Part I Annual Report Ide	entification Information			Inspection	
For calendar plan year 2014 or fisca		and ending 12/31/20	014		
A This return/report is for:	a multiemployer plan;	a multiple-employer plan (Filers checking participating employer information in acco			ons); or
	a single-employer plan;	a DFE (specify)			
B This return/report is:	the first return/report;	the final return/report;			
	an amended return/report;	a short plan year return/report (less than	12 months).		
C If the plan is a collectively-bargai	ned plan, check here			🕨 🛛	
D Check box if filing under:	X Form 5558;	automatic extension;	the DFVC program;		
	special extension (enter description)				
Part II Basic Plan Infor	mation—enter all requested information	on			
1a Name of plan THE RAILROAD EMPLOYEES NAT	FIONAL VISION PLAN		1b	Three-digit plan number (PN) ▶	509
			1c	Effective date of pla 01/01/1999	an
2a Plan sponsor's name and addre	ess; include room or suite number (emplo	oyer, if for a single-employer plan)	2b	Employer Identifica	ition
NATIONAL CARRIERS' CONFERE	NCE COMMITTEE			Number (EIN) 52-1036399	
251 - 18TH STREET SOUTH SUITE	2c	2c Plan Sponsor's telephone number 571-336-7600			
ARLINGTON, VA 22202			2d	Business code (see instructions) 482110	÷

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	Filed with authorized/valid electronic signature.	10/13/2015	A. K. GRADIA			
HERE	Signature of plan administrator	Date	Enter name of individu	al signing as plan administrator		
SIGN HERE						
	Signature of employer/plan sponsor	Date	Enter name of individu	al signing as employer or plan sponsor		
SIGN HERE						
NEKE						
	Signature of DFE	Date	Enter name of individu	al signing as DFE		
Preparer	Signature of DFE 's name (including firm name, if applicable) and address (include n			Preparer's telephone number		
				Preparer's telephone number (optional)		
	's name (including firm name, if applicable) and address (include i Y A. HELLER, CPA			Preparer's telephone number		

3a	Plan administrator's name and address 🛛 Same as Plan Sponsor	3b Administrator's EIN		
			ninistrator's telephone nber	
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	4b EIN	1	
а	Sponsor's name	4c PN		
5	Total number of participants at the beginning of the plan year	5	148933	
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)	148933	
a(2	2) Total number of active participants at the end of the plan year	. 6a(2)	148173	
b	Retired or separated participants receiving benefits	. 6b		
С	Other retired or separated participants entitled to future benefits	. 6c		
d	Subtotal. Add lines 6a(2), 6b, and 6c.	. 6d	148173	
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	. 6e		
f	Total. Add lines 6d and 6e.	. 6f	0	
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 that 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	43	

8a 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: 4E

9a	Plan fu	nding	arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)				
	(1)	X	Insurance		(1)	X	In	surance
	(2)		Code section 412(e)(3) insurance contracts		(2)		Co	ode section 412(e)(3) insurance contracts
	(3)		Trust		(3)		Tr	ust
	(4)		General assets of the sponsor		(4)		Ge	eneral assets of the sponsor
10	Check	all ap	plicable boxes in 10a and 10b to indicate which schedules are at	tache	d, and, w	vhere	e ind	icated, enter the number attached. (See instructions)
а	Pensio	on Sc	hedules	b General Schedules				
	(1)		R (Retirement Plan Information)		(1)			H (Financial Information)
	(2)		MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	Π		I (Financial Information – Small Plan)
		_	Purchase Plan Actuarial Information) - signed by the plan		(3)	X	_1	A (Insurance Information)
			actuary		(4)			C (Service Provider Information)
	(3)		SB (Single-Employer Defined Benefit Plan Actuarial		(5)			D (DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)			G (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans) 11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) 11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)

11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 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_

CFORM 5500) Constraint Constraint <thconstraint< th=""> Constraint Constra</thconstraint<>	SCHEDULE		Insurance Information				OMB No. 1210-0110	
Department of Later Provide Ministration This Form is Open to Public Inspection Pendore Bendit Guarney Corporation Insurance companies are required to provide the information pursuant to ENISA section 103(a)(2). This Form is Open to Public Inspection For calendar plan year 2014 or fiscal plan year beginning 0.101/2014 and ending 12/31/2014 A Name of plan B Three-digit plan number (PN) 509 C. Plan sponsor's name as shown on time 2a of Form 5500 D Employee Identification Number (EIN) NATIONAL CARRIERS CONFERENCE COMMITTEE D Employee Identification Number (EIN) 60 a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. Coverage Information: 1 Coverage Information: (e) Contract or jessons covered at end of policy or contract year Policy or contract year (b) EIN (c) NAIC (d) Contract or jessons covered at end of policy or contract year (f) From (g) To 43-0949844 71870 9859752 404793 01/01/2014 12/31/2014 2 Instrance fee and commissions paid (b) Total amount of fees paid (f) Total amount of fees paid (g) Name and address of the agent, broker,	Department of the Treas	sury						2014
Image: Description Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This Form is Open to Public inspection Perice Related plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014 A Name of plan THE RAILROAD EMPLOYEES NATIONAL VISION PLAN B Three-digit plan number (PN) 509 C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN) 509 Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract or 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 carrier Partonal (c) NAIC (b) Contract or identification number (parts) Policy or contract year (b) EIN (c) NAIC (d) Contract or identification number (p) Approximate number of policy or contract year Policy or contract year (a) Tasto 9859752 404793 01/01/2014 12/31/2014 2 Insurance fee and commissions paid (b) Total amount of fees paid (b) Total amount of fees paid 3 3 Persons receiving commissions paid (c) Amount of commissions paid (d) Purpose (e) Organization commissions paid <td< td=""><td></td><td></td><td></td><td>·</td><td></td><td>).</td><td></td><td></td></td<>				·).		
For calendar plan year 2014 or fisca plan year beginning 01/01/2014 and ending 12/31/2014 A Name of plan B Three-digit plan number (PN) 509 C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN) 52-1036399 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 carrier EYEMED VISION CARE (e) Approximate number of policy or contract year Policy or contract year (b) EIN (c) NAIC 9859752 404793 01/01/2014 12/31/2014 2 Insurance fee and commission information. Enter the total fees and total commissions paid. (b) Total amount of commissions paid (b) Total amount of commissions paid (b) Total amount of fees paid (a) Total amount of commissions and fees. (Complete as many entries as needed to report all persons). (e) Organization commissions or fees were paid (e) Organization commissions or fees were paid (b) Amount of sales and base Fees and other commissions paid (e) Organization commissions or fees were paid			Insurance companies	are required to provide t	the informat	ion	This Fo	
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NATIONAL CARRIERS: CONFERENCE COMMITTEE 52-1036399 Part 1 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 carrier EYEMED VISION CARE (b) EIN (c) NAIC (c) Part 1 (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year (b) EIN (c) NAIC (c) Ages952 404793 43-0949844 71870 9859752 404793 (a) Total amount of commissions paid (b) Total amount of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (b) Amount of sales and base Fees and other commissions paid (e) Organization columnee		YEES NATION	AL VISION PLAN		-	0	N) 🕨	509
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	(b) Amount of sales and base					4		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid		id	(c) Amount		(d) Purpose	9		(e) Organization code
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
		(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	

(b) Amount of sales and base					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
For Penerwark Peduation Act Nation and OND Control Numbers, and the instructions for Form FEOD					

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2014 v. 140124

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

I	(e) Organization			
(c) Amount	(d) Purpose	code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				
	(c) Amount	Fees and other commissions paid (c) Amount (d) Purpose ame 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
 code

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

(b) Amount of sales and base		(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			l
			1

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

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

Schedule A (Form 5500) 2014

Page 3

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for p					as a unit for purposes of	
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	tracts With Allocated Funds:				
	а	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 cor retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	-					
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st	- Constant	shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	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)			
		•				
	f	(5) Total deductions				

m ☐ Other (specify) ▶

		Schedule A (Form 5500) 2014		Page 4	
Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of th information may be combined for reporting purposes if such contract the entire group of such individual contracts with each carrier may be				perience-rated as a unit. Where contra	
8	Benefit	and contract type (check all applicable boxes)			
	a 🗌 I	Health (other than dental or vision)	b Dental	C 🛛 Vision	d Life insurance
	e 🗌 1	Temporary disability (accident and sickness)	f Long-term disability	g Supplemental unemployment	h Prescription drug
	i 🗌 🤋	Stop loss (large deductible)	j 🔲 HMO contract	k PPO contract	I Indemnity contract

9	Experience-rated contracts:						
	а	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)		
	С	Remainder of premium: (1) Retention charges (on an accrual basis)					
		(A) Commissions	9c(1)(A)				
		(B) Administrative service or other fees					
		(C) Other specific acquisition costs					
		(D) Other expenses	9c(1)(D)				
		(E) Taxes	9c(1)(E)				
		(F) Charges for risks or other contingencies	9c(1)(F)				
		(G) Other retention charges	9c(1)(G)				
		(H) Total retention			9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These amounts were paid ir	n cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	r retirement	9d(1)		
		(2) Claim reserves			9d(2)		
		(3) Other reserves			9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include amount entered	d in line 9c(2)	.)	9e		
10) No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carrier			10a	1:	3818768
	b	If the carrier, service, or other organization incurred any specific costs in c	connection wit	th the acquisition or			
		retention of the contract or policy, other than reported in Part I, line 2 above	ve, report amo	ount	10b		

Specify nature of costs

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

(Rev. August 2012) File Certain Employee Plan Department of the Treasury For Privacy Act and Paperwork Reduction Act M Information about Form 5558 and its instructions is at Part I Identification A Name of filer, plan administrator, or plan sponsor (see instructions) NATIONAL CARRIERS ' CONFERENCE COMMITTEE Number, street, and room or suite number (If a P.O. box, see instructions) 251 - 18TH STREET, SOUTH, SUITE 750 City or town, state, and ZIP code ARLINGTON, VA 22202 C Plan name		e instructions). (EIN) (9 digits	th IRS Or	1ly
A Name of filer, plan administrator, or plan sponsor (see instructions) NATIONAL CARRIERS' CONFERENCE COMMITTEE Number, street, and room or suite number (If a P.O. box, see instructions) 251 - 18TH STREET, SOUTH, SUITE 750 City or town, state, and ZIP code ARLINGTON, VA 22202	∑ Employer identification number X·xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	(EIN) (9 digits		
NATIONAL CARRIERS' CONFERENCE COMMITTEE Number, street, and room or suite number (If a P.O. box, see instructions) 251 - 18TH STREET, SOUTH, SUITE 750 City or town, state, and ZIP code ARLINGTON, VA 22202	∑ Employer identification number X·xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	(EIN) (9 digits		
Number, street, and room or suite number (If a P.O. box, see instructions) 251 - 18TH STREET, SOUTH, SUITE 750 City or town, state, and ZIP code ARLINGTON, VA 22202	► 52-1036399			
City or town, state, and ZIP code ARLINGTON, VA 22202				
ARLINGTON, VA 22202			~~~	
C Plan name		9 algits YVY-VV-V	~~~)	
	Plan n	umber Pla	n _i year en	_
		MM	DD	YYYY
1 THE RAILROAD EMPLOYEES NATIONAL VISION P Part II Extension of Time To File Form 5500 Series, and/or Form		9 12	31	14
1 Check this box if you are requesting an extension of time on line 2 to file the first		for the plan lie		
Part 1, C above.	st Form 5500 series returninepon	for the plant is		
 I request an extension of time until <u>10/15/2015</u> to file Form 5500 seri Note. A signature IS NOT required if you are requesting an extension to file F 				
3 I request an extension of time untilto file Form 8955-SSA (Note. A signature IS NOT required if you are requesting an extension to file Form	• •			
The application is automatically approved to the date shown on line 2 and/or line 3 (abo normal due date of Form 5500 series, and/or Form 8955-SSA for which this es 3 (above) is not later than the 15th day of the third month after the normal du Part III Extension of Time To File Form 5330 (see instructions)	xtension is requested, and (b) e date.	the date on li	ne 2 and/	or line
4 I request an extension of time untilto file Form 5330.				
You may be approved for up to a 6 month extension to file Form 5330, after the	1 1	130.		
a Enter the Code section(s) imposing the tax	▶a			
b Enter the payment amount attached		► b		
 c For excise taxes under section 4980 or 4980F of the Code, enter the reversion 5 State in detail why you need the extension: 	n/amendment date	► c		
······································				
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	· · · · · · · · · · · · · · · · · · ·			
Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this for this application.	rm are true, correct, and complete, and t	hat I am authorize	d to prepare	
Signature		Date ►	·····	

Form 5500	Annual	Return/Report o	of Employee Benefit	Plan	o	VIB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service Department of Labor	Internal Revenue Service and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and Department of Labor sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).		2014			
Employee Benefits Security Administration Pension Benefit Guaranty Corporation			ies in accordance with to the Form 5500.			n Is Open to Inspection
Part Annual Repor	rt Identification	Information				
For calendar plan year 2014 or			and endin			
) X a multiemplo		a multiple-employer plan (Filers		hov must atta	ch a list of
(participating employer inform instructions); or			
(2			a DFE (specify)			
B This return/report is: (1	* h{	· · ·	the final return/report;			
(2) C If the plan is a collectively	•		a short plan year return/report (less	han 12 months).		► .
D Check box if filing under:	X Form 5558;		automati	c extension;	·····	DFVC program;
	إستسترا	ision (enter description)		e extension,		n to program,
	ا اسا					
Part II Basic Plan Inf	ormation - ent	er all requested information				
THE RAILROAD EMPLOY	EES NATIONAL	VISTON PLAN	16	Three-digit plan number	(PN) ►	509
	DES MATIONA	J VIDION I DAN	10	Effective date of		
				01/01/19	999	
2 a Plan sponsor's name and address	; include room or suite n	umber (employer, if for a single-	employer plan) 2b	Employer Identifi	ication Number (I	EIN)
				52-10363	399	··
			20	Plan Sponsor's t	-	
				571-336-'		
			20	Business code (s	see instructions)	
				<u>482110</u>	. K.	± 1€ γ
NATIONAL CARRIERS'	CONFERENCE C	`^WWT TTTE	1 1 1	() () () () () () () () () () () () () (
251 - 18TH STREET,			ž.			an a
ARLINGTON, VA 22202					s	1980 (m. 1
Caution: A penalty for the late of						
Under penalties of perjury and other penal well as the electronic version of this return				mpanying scheduli	es, statements a	nd attachments, as
HERE Q.K. H.	0	Inlia lic				
	Jera	Date	A. K. GRADIA Enter name of individual signing	as olan anministra	tor	
1.700						
SIGN						
Signature of employer/plan sp	onsor	Date	Enter name of individual signing	as employer or pla	in sponsor	
SIGN						
HERE						
Signature of DFE		Date	Enter name of individual signing	as DFE		
Preparer's name (including firm name,	if applicable) and addr	ess (include room or suite num	ber) (optional)	Preparer's te	lephone number	(optional)
TIMOTHY A. HELLER,	CPA					
TMDG, LLC.				[443]	743-1277	
500 E PRATT ST STE						
BALTIMORE	MD	21202-3178				
For Paperwork Reduction Act	Notice and OMB C	ontrol Numbers, see the	e instructions for Form 5500.			m 5500 (2014) 40124

E8PA9401L 03/06/15

3c A lift the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: 4b Em 3 Sometrix name 4c Fm 5 Total number of participants at the beginning of the plan year 5 148933 6 Number of participants at of the end of the plan year 5 148933 a(1) Total number of active participants at the beginning of the plan year 5a(2) 148933 a(2) Total number of active participants at the beginning of the plan year 5a(2) 148933 a(2) Total number of active participants at the beginning of the plan year 5a(2) 148933 a(3) Total number of active participants entilled to future benefits. 5a(2) 148933 a(2) Total number of active participants entilled to future benefits. 5a(4) 148173 b Total Add lines 6a(2) 6a(1) 148173 5a(4) 148173 b Total Add lines 6a(2) 6a(1) 148173 5a(4) 5a(4) 148173 b Total Add lines 6a(2) 6a(1) 6a(1) 148173 5a(4) 5a(4) 5a(4) 5a(4) 5a(4) 5a(4) 5a(3 a Plan administrator's name and address X Same as Plan Sponsor	3b Administra	3b Administrator's EIN	
4 If the name andor 2NV of the plan sponsor has changed since the last return/report lied for this plan, enter the name. EVA and the plan under from the last return/report. 4 5 Total number of participants at the beginning of the plan year. 5 148933 6 Number of participants as of the end of the plan year. 5 148933 a(1) Total number of active participants at the beginning of the plan year. 5 148933 a(2) Total number of active participants at the beginning of the plan year. 5 6 a(2) Total number of active participants at the end of the plan year. 5 6 a(2) Total number of active participants at the end of the plan year. 6 6 a Subtoal. Add lines 5(a), 60, and 6c. 6 6 148173 b Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6 6 6 f Total. Add lines 5d and 6e. 6 6 6 6 6 g Number of participants whit account balances as of the end of the plan year with accound benefits that were less than 100% wested. 7 43 6 6 6 6 6 6 6 6 6 6 6		3c Administra	tor's telephone number	
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Receipt Confirmation Code

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
	plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions 29 CFR 2520.101-2.)
if 'Ye	es' is checked, complete lines 11b and 11c.
11b is the	e plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2) Yes No
repoi	r the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual rt, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing irements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

EBPA9403L 01/14/15