

Form 5500	Annual Return/Report of Employee Benefit Plan <p>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).</p> <p style="text-align: center;">► Complete all entries in accordance with the instructions to the Form 5500.</p>	<small>OMB Nos. 1210-0110 1210-0089</small> 2024 <small>This Form is Open to Public Inspection</small>
Department of the Treasury Internal Revenue Service		
Department of Labor Employee Benefits Security Administration		
Pension Benefit Guaranty Corporation		

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024**

and ending **12/31/2024**

A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
 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-bargained plan, check here. ►
D Check box if filing under: Form 5558 automatic extension the DFVC program
 special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ►

Part II Basic Plan Information—enter all requested information

1a Name of plan

SEIU HEALTH AND WELFARE FUND

1b Three-digit plan number (PN) ►	501
--	------------

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)

SEIU HEALTH AND WELFARE FUND WELFARE FUND

2b Employer Identification Number (EIN)

52-0904354

C/O TSEGAW MENGISTU

1800 MASSACHUSETTS AVE., NW,
WASHINGTON, DC 20036

1800 MASSACHUSETTS AVE., NW, #301
WASHINGTON, DC 20036

1c Effective date of plan
05/01/1969

2c Plan Sponsor's telephone number
202-730-7511

2d Business code (see instructions)
561790

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.	09/18/2025	MEGAN SWEENEY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	09/18/2025	MEGAN SWEENEY
	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.

Form 5500 (2024)

v. 240311

3a Plan administrator's name and address <input checked="" 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:		4b EIN
a Sponsor's name		4d PN
c Plan Name		
5 Total number of participants at the beginning of the plan year		5 4913
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) 4913
a(2) Total number of active participants at the end of the plan year		6a(2) 5110
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 5110
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6e
f Total. Add lines 6d and 6e.....		6f
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)		6g(1)
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		6g(2)
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)		7 121
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:		
4A 4B 4D 4E 4Q 4U		
9a Plan funding arrangement (check all that apply)		9b Plan benefit arrangement (check all that apply)
(1) <input checked="" type="checkbox"/> Insurance		(1) <input checked="" 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 checked="" type="checkbox"/> Trust		(3) <input checked="" type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor		(4) <input type="checkbox"/> General assets of the sponsor
10 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
(1) <input type="checkbox"/> R (Retirement Plan Information)		(1) <input checked="" type="checkbox"/> H (Financial Information)
(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary		(2) <input type="checkbox"/> I (Financial Information – Small Plan)
(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		(3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached 6
(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____		(4) <input checked="" type="checkbox"/> C (Service Provider Information)
(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)		(5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information)
		(6) <input type="checkbox"/> 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.) 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 2024 Form M-1 annual report. If the plan was not required to file the 2024 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 _____

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

OMB No. 1210-0110

2024

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).

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan
SEIU HEALTH AND WELFARE FUND

B Three-digit plan number (PN) ► **501**

C Plan sponsor's name as shown on line 2a of Form 5500
SEIU HEALTH AND WELFARE FUND WELFARE FUND

D Employer Identification Number (EIN)
52-0904354

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

AMALGAMATED LIFE INSURANCE COMPANY

(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
13-5501223	60216	26AN02	2445	01/01/2024	12/31/2024

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

0 **0**

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

(b) Amount of sales and base commissions paid	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) 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		

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 purposes of this report.		
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.....	6d	
Specify nature of costs ►		
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ►		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ► <input type="checkbox"/>		
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ►		
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)	
►		
(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	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
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 organizations(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	73239
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**Provision of 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. ►

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

OMB No. 1210-0110

2024

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).

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan
SEIU HEALTH AND WELFARE FUND

B Three-digit plan number (PN) ► **501**

C Plan sponsor's name as shown on line 2a of Form 5500
SEIU HEALTH AND WELFARE FUND WELFARE FUND

D Employer Identification Number (EIN)
52-0904354

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

KAISER FOUNDATION HEALTH PLAN OF MID-ATLANTIC STATES, INC

(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
52-0954463	95639	6705	29	01/01/2024	12/31/2024

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

0 **0**

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

(b) Amount of sales and base commissions paid	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) 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		

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 purposes of this report.		
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.....	6d	
Specify nature of costs ►		
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ►		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ► <input type="checkbox"/>		
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ►		
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)	
►		
(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	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
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 organizations(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 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	175293
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**Provision of 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. ►

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

OMB No. 1210-0110

2024

**This Form is Open to Public
Inspection**

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan SEIU HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ► 501
C Plan sponsor's name as shown on line 2a of Form 5500 SEIU HEALTH AND WELFARE FUND WELFARE FUND	D Employer Identification Number (EIN) 52-0904354

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

BLUE CROSS BLUE SHIELD OF ILLINOIS

(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
36-1236610	70670	183134	819	01/01/2024	12/31/2024

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

0 **0**

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

(b) Amount of sales and base commissions paid	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) 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		

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 purposes of this report.		
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.....	6d	
Specify nature of costs ►		
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ►		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ► <input type="checkbox"/>		
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ►		
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)	
►		
(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	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
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 organizations(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 type="checkbox"/> Other (specify) ►			

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	3845623
(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)	3845623
b Benefit charges (1) Claims paid.....	9b(1)	3615351
(2) Increase (decrease) in claim reserves.....	9b(2)	
(3) Incurred claims (add (1) and (2)).....	9b(3)	3615351
(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)	121041
(C) Other specific acquisition costs	9c(1)(C)	
(D) Other expenses	9c(1)(D)	134405
(E) Taxes.....	9c(1)(E)	
(F) Charges for risks or other contingencies	9c(1)(F)	
(G) Other retention charges.....	9c(1)(G)	-25175
(H) Total retention.....	9c(1)(H)	230271
(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**Provision of 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. ►

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

OMB No. 1210-0110

2024

**This Form is Open to Public
Inspection**

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan SEIU HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ► 501
C Plan sponsor's name as shown on line 2a of Form 5500 SEIU HEALTH AND WELFARE FUND WELFARE FUND	D Employer Identification Number (EIN) 52-0904354

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

GUARDIAN LIFE INSURANCE COMPANY OF 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
13-5123390	64246	00544202	27	01/01/2024	12/31/2024

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

826 **0**

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

WEINER INS INC **13951 N. SCOTTSDALE ROAD SUITE 131**
SCOTTSDALE, AZ 85254

(b) Amount of sales and base commissions paid	Fees and other commissions paid			(e) Organization code
	(c) Amount	(d) Purpose		
826				3

(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) 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		

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 purposes of this report.		
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.....	6d	
Specify nature of costs ►		
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ►		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ► <input type="checkbox"/>		
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ►		
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)	
►		
(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	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
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 organizations(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 checked="" 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 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	8262
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**Provision of 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. ►

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

OMB No. 1210-0110

2024

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).

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan
SEIU HEALTH AND WELFARE FUND

B Three-digit plan number (PN) ► **501**

C Plan sponsor's name as shown on line 2a of Form 5500
SEIU HEALTH AND WELFARE FUND WELFARE FUND

D Employer Identification Number (EIN)
52-0904354

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

AMALGAMATED LIFE INSURANCE COMPANY (SL)

(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
13-5501223	60216	SL1126	4822	01/01/2024	12/31/2024

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

0 **0**

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

(b) Amount of sales and base commissions paid	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) 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		

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 purposes of this report.		
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.....	6d	
Specify nature of costs ►		
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ►		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ► <input type="checkbox"/>		
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ►		
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)	
►		
(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	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
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 organizations(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 checked="" 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	491898
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**Provision of 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. ►

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

OMB No. 1210-0110

2024

**This Form is Open to Public
Inspection**

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan SEIU HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ► 501
C Plan sponsor's name as shown on line 2a of Form 5500 SEIU HEALTH AND WELFARE FUND WELFARE FUND	D Employer Identification Number (EIN) 52-0904354

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

KAISER FOUNDATION HEALTH PLAN INC (CA)

(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
94-1340523	00000	103153	78	07/01/2023	06/30/2024

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

0 **0**

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

(b) Amount of sales and base commissions paid	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) 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		

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 purposes of this report.		
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.....	6d	
Specify nature of costs ►		
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ►		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ► <input type="checkbox"/>		
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ►		
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)	
►		
(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	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
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 organizations(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 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	571247
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**Provision of 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. ►

**SCHEDULE C
(Form 5500)**Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation**Service Provider Information**

OMB No. 1210-0110

2024**This Form is Open to Public
Inspection.**For calendar plan year 2024 or fiscal plan year beginning **01/01/2024**and ending **12/31/2024****A** Name of plan**SEIU HEALTH AND WELFARE FUND****B** Three-digit
plan number (PN)**501****C** Plan sponsor's name as shown on line 2a of Form 5500**SEIU HEALTH AND WELFARE FUND WELFARE FUND****D** Employer Identification Number (EIN)**52-0904354****Part I Service Provider Information (see instructions)**

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.

1 Information on Persons Receiving Only Eligible Indirect Compensation

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 who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation**BNYM AFL-CIO CF SL BROAD MARKET STO**

25-6078093

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation**ARA CORE PROPERTY FUND, LP****515 S. FLOWER ST
LOS ANGELES, CA 90071****(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation**LOOP CAPITAL ASSET MANAGEMENT/CORE****425 S. FINANCIAL PLACE, SUITE 2700
CHICAGO, IL 60605****(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, 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)

SEIU NATIONAL INDUSTRY PENSION FUND

52-6148540

(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?
13 50	AFFILIATE	1492707	Yes <input type="checkbox"/> No <input checked="" 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)

UMR, INC.

39-1995276

(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 50	NONE	550239	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	36551	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

GROUP HOSP MED SERV (CAREFIRST)

53-0078070

(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 50	NONE	563292	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"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, 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)

THE SEGAL COMPANY

13-1835864

(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?
11 50	NONE	295535	Yes <input type="checkbox"/> No <input checked="" 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)

CIGNA HEALTH AND LIFE INSURANCE

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 13 31 38 49 50 56 62	ADMINISTRATOR	220030	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)

DELTA DENTAL

52-1479587

(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 50	NONE	162404	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, 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)

WILSON-MCSHANE CORPORATION

41-0956552

(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 50	NONE	69232	Yes <input type="checkbox"/> No <input checked="" 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)

SCHULTHEIS & PANETTIERI, LLP

13-1577780

(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?
15 50	NONE	69201	Yes <input type="checkbox"/> No <input checked="" 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)

MOONEY, GREEN, BAKER & SAINDON LLP

52-1958229

(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?
29 50	NONE	55822	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, 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)

CVS CAREMARK

05-0340626

(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 50	NONE	40937	Yes <input type="checkbox"/> No <input checked="" 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)

GARCIA HAMILTON & ASSOCIATES

76-0589652

(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?
28 51	NONE	31989	Yes <input type="checkbox"/> No <input checked="" 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)

CALIBRE CPA GROUP PLLC

47-0900880

(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?
10 50	NONE	31000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, 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)

MARQUETTE ADVISORS

36-3485298

(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?
27 50	NONE	20000	Yes <input type="checkbox"/> No <input checked="" 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)

WITHUMSMITH+BROWN, PC

22-2027092

(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?
15 50	NONE	17221	Yes <input type="checkbox"/> No <input checked="" 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)

JONAS GUDJONSSON

1800 MASSACHUSETTS AVE., NW,
WASHINGTON, DC 20036

(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?
16 50	NONE	13240	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, 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)

AMALGAMATED BANK

13-4920330

(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?
19 51	NONE	12433	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"/>

Part I Service Provider Information (continued)

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
CIGNA HEALTH AND LIFE INSURANCE	12 13 31 38 49 50 56 62	0
(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.	
CASTLIGHT HEALTH 26-1989091	\$3.24 PER PARTICIPANT - INDIRECT COMPENSATION RECEIVED BY CIGNA FROM THIS VENDOR (I) TO DEFRAY CIGNA'S COST FOR THE INFRASTRUCTURE CHANGES REQUIRED TO FACILITATE IMPLEMENTATION OF THIS VENDOR'S CUSTOMER TRANSPARENCY AND ENGAGEMENT SERVICES; (II) AS R	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	12 13 31 38 49 50 56 62	0
(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.	
CITIBANK NA (OMNIBUS) 59-1031071	\$0.01 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.66% - EARNINGS CREDITS ON DAILY FUND BALANCES ASSOCIATED WITH BANK ACCOUNTS UTILIZED IN THE CLAIM ADMINISTRATION BY CIGNA. APPLICABLE TO ALL SELF-FUNDED PLANS FOR EVEMORTH	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	12 13 31 38 49 50 56 62	0
(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.	
OMADA COMPLETE 45-2355015	\$0.17 PER PARTICIPANT - INDIRECT COMPENSATION RECEIVED BY CIGNA FROM THIS PROVIDER FOR SERVICES INCLUDING: SERVICES, AND FACILITATE ENROLLMENT OF SCREENED PARTICIPANTS IN THE OMADA COVERED SERVICES.	

Part I Service Provider Information (continued)

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
CIGNA HEALTH AND LIFE INSURANCE	12 13 31 38 49 50 56 62	0
(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.	
OMADA HEALTH, INC 45-2355015	\$1.23 PER PARTICIPANT - INDIRECT COMPENSATION RECEIVED BY CIGNA FROM THIS PROVIDER FOR SERVICES INCLUDING:(I) EXPLAINING THE OMADA SERVICES TO EXISTING AND PROSPECTIVE CLIENTS; (II) ENCOURAGING AT-RISK INDIVIDUALS WHO MAY BENEFIT FROM THE OMADA SERVI	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	12 13 31 38 49 50 56 62	0
(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.	
VISION SERVICE PLAN 06-1227840	\$0.67 PER PARTICIPANT - INDIRECT COMPENSATION RECEIVED BY CIGNA FROM THIS VENDORFOR CIGNA'S EXPENSES ASSOCIATED WITH ADMINISTERING PLANS WITH VISION BENEFITS.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	12 13 31 38 49 50 56 62	0
(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.	
SAGAMORE NETWORK HOSPITAL 35-1720796	\$0.06 PER PARTICIPANT - NETWORK HOSPITALS HAVE CONTRACTED WITH SAGAMORE HEALTH NETWORK (AN AFFILIATE OF CIGNA) TO PAY NETWORK ADMINISTRATION FEES.	

Part I Service Provider Information (continued)

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
CIGNA HEALTH AND LIFE INSURANCE	12 13 31 38 49 50 56 62	0
(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.	
BANK OF AMERICA (LOCKBOX) 59-1031071	\$0.37 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 4.00%. - EARNINGS CREDITS ASSOCIATED WITH BANK ACCOUNTS UTILIZED BY CIGNA IN THE ADMINISTRATION OF CLAIM OVERPAYMENT RECOVERIES. APPLICABLE TO ALL SELF-FUNDED PLANS ADMINIST	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	12 13 31 38 49 50 56 62	0
(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.	
CIGNA HEALTHY REWARDS VENDOR 59-1031071	\$0.00 PER MEMBER PER YEAR - VOLUME BASED MARKETING FEES PAID BY VENDORS PARTICIPATING IN THE CIGNA HEALTHY REWARDS PROGRAM WHICH OFFERS PLAN PARTICIPANTS DISCOUNTS ON VARIOUS SERVICES.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	12 13 31 38 49 50 56 62	0
(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.	
CITIBANK NA 59-1031071	\$1.97 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.66% - EARNINGS CREDITS ON DAILY FUND BALANCES ASSOCIATED WITH BANK ACCOUNTS UTILIZED IN THE CLAIM ADMINISTRATION BY CIGNA. APPLICABLE TO ALL SELF-FUNDED PLANS UTILIZING CI	

Part I Service Provider Information (continued)

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
CIGNA HEALTH AND LIFE INSURANCE	12 13 31 38 49 50 56 62	0
(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.	
DEUTSCHE BANK 13-4941247	\$0.00 PER PARTICIPANT; AVG ANNUAL RATE OF EARNINGS CREDIT .50% - EARNINGS CREDITS ASSOCIATED WITH BANK ACCOUNTS UTILIZED BY CIGNA IN THE ADMINISTRATION OF DISBURSING CLAIM REFUNDS. APPLICABLE TO ALL SELF-FUNDED PLANS ADMINISTERED BY CIGNA.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	12 13 31 38 49 50 56 62	0
(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.	
JPMORGAN CHASE 59-1031071	\$3.70 PER PARTICIPANT; AVG ANNUAL RATE OF EARNINGS CREDIT 3.34% - EARNINGS CREDITS ON DAILY FUND BALANCES ASSOCIATED WITH BANK ACCOUNTS UTILIZED IN CLAIM ADMINISTRATION BY CIGNA. APPLICABLE TO ALL SELF-FUNDED PLANS UTILIZING JPMORGAN CHASE SERVICES.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	12 13 31 38 49 50 56 62	0
(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.	
CHLIC CORE DEPOSITS 53-1031071	\$4.38 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.54% - EARNINGS CREDITS ASSOCIATED WITH BANK ACCOUNTS UTILIZED BY CIGNA IN THE ADMINISTRATION OF DISBURSING CLAIM REFUNDS. APPLICABLE TO ALL SELF-FUNDED PLANS ADMINISTERED	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Part III	Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)
-----------------	---

a Name:	b EIN:
c Position:	
d Address:	e Telephone:
Explanation:	

a Name:	b EIN:
c Position:	
d Address:	e Telephone:
Explanation:	

a Name:	b EIN:
c Position:	
d Address:	e Telephone:
Explanation:	

a Name:	b EIN:
c Position:	
d Address:	e Telephone:
Explanation:	

a Name:	b EIN:
c Position:	
d Address:	e Telephone:
Explanation:	

**SCHEDULE D
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

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

► **File as an attachment to Form 5500.**

OMB No. 1210-0110

2024

This Form is Open to Public Inspection.

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan SEIU HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ► 501
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 SEIU HEALTH AND WELFARE FUND WELFARE FUND	D Employer Identification Number (EIN) 52-0904354

Part I **Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)**
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: **BNYM MELLON AFL-CIO SL STOCK INDEX**

b Name of sponsor of entity listed in (a): **THE BANK OF NEW YORK MELLON**

c EIN-PN 25-6078093-340	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	7315620
---------------------------------------	-------------------------------	---	----------------

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
-----------------	----------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
-----------------	----------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
-----------------	----------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
-----------------	----------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
-----------------	----------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
-----------------	----------------------	---

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

SCHEDULE H
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

► **File as an attachment to Form 5500.**

OMB No. 1210-0110

2024

**This Form is Open to Public
Inspection**

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan SEIU HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ► 501
C Plan sponsor's name as shown on line 2a of Form 5500 SEIU HEALTH AND WELFARE FUND WELFARE FUND	D Employer Identification Number (EIN) 52-0904354

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets	(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	
b Receivables (less allowance for doubtful accounts):		
(1) Employer contributions	1b(1)	1376283
(2) Participant contributions.....	1b(2)	
(3) Other	1b(3)	1591280
c General investments:		
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	3127196
(2) U.S. Government securities	1c(2)	20583705
(3) Corporate debt instruments (other than employer securities):		
(A) Preferred	1c(3)(A)	
(B) All other.....	1c(3)(B)	2718683
(4) Corporate stocks (other than employer securities):		
(A) Preferred	1c(4)(A)	
(B) Common	1c(4)(B)	
(5) Partnership/joint venture interests	1c(5)	2925731
(6) Real estate (other than employer real property)	1c(6)	
(7) Loans (other than to participants).....	1c(7)	
(8) Participant loans	1c(8)	
(9) Value of interest in common/collective trusts	1c(9)	7195381
(10) Value of interest in pooled separate accounts	1c(10)	7315619
(11) Value of interest in master trust investment accounts	1c(11)	
(12) Value of interest in 103-12 investment entities	1c(12)	
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	109380
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	895355
(15) Other.....	1c(15)	

	(a) Beginning of Year	(b) End of Year
1d Employer-related investments:		
(1) Employer securities.....	1d(1)	
(2) Employer real property.....	1d(2)	
e Buildings and other property used in plan operation	1e	
f Total assets (add all amounts in lines 1a through 1e).....	1f	39627639
Liabilities		
g Benefit claims payable	1g	4308100
h Operating payables	1h	98269
i Acquisition indebtedness.....	1i	
j Other liabilities.....	1j	2412070
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	6818439
Net Assets		
l Net assets (subtract line 1k from line 1f).....	1l	32809200
		38171193

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income	(a) Amount	(b) Total
a Contributions:		
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	59449320
(B) Participants	2a(1)(B)	280009
(C) Others (including rollovers).....	2a(1)(C)	
(2) Noncash contributions.....	2a(2)	
(3) Total contributions. Add lines 2a(1)(A), (B) , (C) , and line 2a(2)	2a(3)	59729329
b Earnings on investments:		
(1) Interest:		
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	67819
(B) U.S. Government securities	2b(1)(B)	617735
(C) Corporate debt instruments	2b(1)(C)	88277
(D) Loans (other than to participants)	2b(1)(D)	
(E) Participant loans	2b(1)(E)	
(F) Other	2b(1)(F)	288322
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)	1062153
(2) Dividends: (A) Preferred stock.....	2b(2)(A)	
(B) Common stock	2b(2)(B)	
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	
(D) Total dividends. Add lines 2b(2)(A), (B) , and (C)	2b(2)(D)	
(3) Rents	2b(3)	
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	16338826
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	16307994
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)	30832
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	
(B) Other	2b(5)(B)	349689
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)	349689

	(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	2b(6)	311233
(7) Net investment gain (loss) from pooled separate accounts.....	2b(7)	
(8) Net investment gain (loss) from master trust investment accounts	2b(8)	
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)	
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)	
c Other income	2c	836238
d Total income. Add all income amounts in column (b) and enter total.....	2d	62319474

Expenses

e Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	50243304
(2) To insurance carriers for the provision of benefits	2e(2)	3008757
(3) Other.....	2e(3)	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)	53252061
f Corrective distributions (see instructions)	2f	
g Certain deemed distributions of participant loans (see instructions).....	2g	
h Interest expense.....	2h	
i Administrative expenses:		
(1) Salaries and allowances	2i(1)	
(2) Contract administrator fees	2i(2)	2528459
(3) Recordkeeping fees	2i(3)	86422
(4) IQPA audit fees	2i(4)	31000
(5) Investment advisory and investment management fees	2i(5)	84038
(6) Bank or trust company trustee/custodial fees	2i(6)	12433
(7) Actuarial fees	2i(7)	269341
(8) Legal fees	2i(8)	55822
(9) Valuation/appraisal fees	2i(9)	
(10) Other trustee fees and expenses	2i(10)	36083
(11) Other expenses.....	2i(11)	601822
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)	3705420
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j	56957481

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k	5361993
l Transfers of assets:		
(1) To this plan.....	2l(1)	
(2) From this plan	2l(2)	

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) Unmodified (2) Qualified (3) Disclaimer (4) Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d) (3) neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **CALIBRE CPA GROUP PLLC**

(2) EIN: **47-0900880**

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) This form is filed for a CCT, PSA, DCG or MTIA. (2) It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)

b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.).....

c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)

d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.).....

e Was this plan covered by a fidelity bond?

f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?

g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?.....

h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?.....

i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)

j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.).....

k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?

l Has the plan failed to provide any benefit when due under the plan?.....

m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.).....

n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?..... Yes No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

	Yes	No	Amount
4a		<input checked="" type="checkbox"/>	
4b		<input checked="" type="checkbox"/>	
4c		<input checked="" type="checkbox"/>	
4d		<input checked="" type="checkbox"/>	
4e	<input checked="" type="checkbox"/>		3000000
4f		<input checked="" type="checkbox"/>	
4g	<input checked="" type="checkbox"/>		10852170
4h		<input checked="" type="checkbox"/>	
4i	<input checked="" type="checkbox"/>		
4j	<input checked="" type="checkbox"/>		
4k		<input checked="" type="checkbox"/>	
4l		<input checked="" type="checkbox"/>	
4m		<input checked="" type="checkbox"/>	
4n		<input checked="" type="checkbox"/>	

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.



**SERVICE EMPLOYEES INTERNATIONAL UNION
HEALTH AND WELFARE FUND**

FINANCIAL STATEMENTS

DECEMBER 31, 2024





SERVICE EMPLOYEES INTERNATIONAL UNION HEALTH AND WELFARE FUND

FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

CONTENTS

	PAGE
Independent Auditor's Report	1
Statements of Net Assets Available for Benefits	4
Statements of Changes in Net Assets Available for Benefits	5
Statements of Benefit Obligations	6
Statements of Changes in Benefit Obligations	7
Notes to Financial Statements	9
Supplemental Information	
Schedules of Administrative Expenses	20
Schedule of Assets (Held at End of Year)	21
Schedule of Reportable Transactions	22



INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of the
Service Employees International Union Health and Welfare Fund

Opinion

We have audited the accompanying financial statements of Service Employees International Union Health and Welfare Fund (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of Service Employees International Union Health and Welfare Fund as of December 31, 2024 and 2023, and the changes in its net assets available for benefits and changes in its benefit obligations for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Service Employees International Union Health and Welfare Fund and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.



In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Service Employees International Union Health and Welfare Fund's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Management is also responsible for maintaining a current plan instrument, including all plan amendments, administering the plan, and determining that the plan's transactions are presented and disclosed in the financial statements are in conformity with the plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements, including omissions, are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for a reasonable period of time.



We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of assets (held at end of year) and schedule of reportable transactions are presented for purposes of additional analysis and are not a required part of the financial statements but are supplemental information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying schedules is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

Other Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The schedules of administrative expenses are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Calibre CPA Group, PLLC

Bethesda, MD
September 26, 2025



SERVICE EMPLOYEES INTERNATIONAL UNION HEALTH AND WELFARE FUND

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

DECEMBER 31, 2024 AND 2023

	2024	2023
Assets		
Assets		
Investments - at fair value	<u>\$ 37,232,532</u>	<u>\$ 33,532,880</u>
Receivables		
Employer contributions, net of allowance	1,386,895	1,376,283
Due from related parties	50,416	97,251
Accrued interest	119,134	131,150
Pending transactions	-	23,322
Other receivables	<u>1,285,171</u>	<u>955,442</u>
	<u>2,841,616</u>	<u>2,583,448</u>
Prepaid expenses	13,483	384,115
Cash	<u>6,371,207</u>	<u>3,127,196</u>
Total assets	<u>46,458,838</u>	<u>39,627,639</u>
Liabilities and Net Assets		
Liabilities		
Accounts payable	116,066	98,269
Deferred contribution income	2,805,125	1,571,521
Due to related parties	136,618	145,826
Health reimbursement accounts	147,397	184,980
Cash overdraft - outstanding checks	<u>86,439</u>	<u>509,743</u>
Total liabilities	<u>3,291,645</u>	<u>2,510,339</u>
Net assets available for benefits	<u>\$ 43,167,193</u>	<u>\$ 37,117,300</u>

See accompanying notes to financial statements.



SERVICE EMPLOYEES INTERNATIONAL UNION HEALTH AND WELFARE FUND

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
Additions		
Investment income		
Net appreciation in fair value of investments	\$ 691,754	\$ 875,532
Interest	<u>1,062,153</u>	<u>954,400</u>
	1,753,907	1,829,932
Less: investment expenses	<u>(96,471)</u>	<u>(91,327)</u>
Net investment income	<u>1,657,436</u>	<u>1,738,605</u>
Contributions		
Employers, net of payroll audit expenses of \$5,718 and \$1,966, respectively	59,449,320	50,902,299
Employees	280,009	219,531
Stop loss reimbursements	835,120	-
Other income	<u>1,118</u>	<u>1,913,153</u>
Total contributions	<u>60,565,567</u>	<u>53,034,983</u>
Total additions	<u>62,223,003</u>	<u>54,773,588</u>
Deductions		
Benefits		
Self-funded claims paid	38,247,317	40,317,525
Prescription drug benefits	9,402,565	8,610,034
Dental benefits	1,905,522	1,770,906
Stop-loss insurance premiums	491,898	271,902
Cost containment fees for PPO	81,961	589,749
PPO and HMO insurance premiums	2,361,659	2,264,518
Life insurance premiums	<u>73,239</u>	<u>57,569</u>
Total benefits	<u>52,564,161</u>	<u>53,882,203</u>
Administrative expenses	<u>3,608,949</u>	<u>4,044,344</u>
Total deductions	<u>56,173,110</u>	<u>57,926,547</u>
Net change	6,049,893	(3,152,959)
Net assets available for benefits		
Beginning of year	<u>37,117,300</u>	<u>40,270,259</u>
End of year	<u>\$ 43,167,193</u>	<u>\$ 37,117,300</u>

See accompanying notes to financial statements.



SERVICE EMPLOYEES INTERNATIONAL UNION HEALTH AND WELFARE FUND

STATEMENTS OF BENEFIT OBLIGATIONS

DECEMBER 31, 2024 AND 2023

	2024	2023
Amounts currently payable to or for participants, beneficiaries and dependents		
Medical claims payable	\$ 513,600	\$ 438,768
Prescription drug program	<u>71,520</u>	<u>61,464</u>
Total amounts currently payable for participants, beneficiaries, and dependents	<u>585,120</u>	<u>500,232</u>
Other obligations for current benefit coverage, at present value of estimated amounts		
Claims incurred but not reported	4,410,880	3,807,868
Accumulated eligibility credits	<u>34,228</u>	<u>32,030</u>
Total other obligations for current benefits at present value of estimated amounts	<u>4,445,108</u>	<u>3,839,898</u>
Postretirement benefit obligations, net of amounts currently payable		
Current retirees	20,769,505	19,090,139
Other participants fully eligible for benefits	5,521,667	4,881,424
Other participants not fully eligible for benefits	<u>2,052,943</u>	<u>2,271,157</u>
Total postretirement benefit obligations	<u>28,344,115</u>	<u>26,242,720</u>
Total benefit obligations	<u><u>\$ 33,374,343</u></u>	<u><u>\$ 30,582,850</u></u>

See accompanying notes to financial statements.



SERVICE EMPLOYEES INTERNATIONAL UNION HEALTH AND WELFARE FUND

STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
Amounts currently payable for insurance premiums		
Balance at beginning of year	\$ -	\$ -
Premiums due to insurance companies	2,926,796	2,593,989
Premiums paid to insurance companies	<u>(2,926,796)</u>	<u>(2,593,989)</u>
Balance at end of period	-	-
Amounts currently payable to or for participants, beneficiaries, and dependents for medical claims		
Balance at beginning of year	438,768	487,704
Claims reported and approved for payment	38,404,110	40,858,338
Claims paid	<u>(38,329,278)</u>	<u>(40,907,274)</u>
Balance at end of year	<u>513,600</u>	<u>438,768</u>
Amounts currently payable to or for participants, beneficiaries, and dependents for dental claims		
Balance at beginning of year	-	-
Claims reported and approved for payment	1,905,522	1,770,906
Claims paid	<u>(1,905,522)</u>	<u>(1,770,906)</u>
Balance at end of year	-	-
Amounts currently payable to or for participants, beneficiaries, and dependents for prescription drug program		
Balance at beginning of year	61,464	49,464
Claims reported and approved for payment	9,412,621	8,622,034
Claims paid	<u>(9,402,565)</u>	<u>(8,610,034)</u>
Balance at end of year	<u>71,520</u>	<u>61,464</u>

See accompanying notes to financial statements.



SERVICE EMPLOYEES INTERNATIONAL UNION HEALTH AND WELFARE FUND

STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS (CONTINUED)

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
Other obligations for current benefits, at present value coverage of estimated amounts		
Balance at beginning of year	\$ 3,839,898	\$ 4,122,978
Net change during period		
Claims incurred but not reported	603,012	(280,664)
Accumulated eligibility credits	<u>2,198</u>	<u>(2,416)</u>
Balance at end of year	<u><u>4,445,108</u></u>	<u><u>3,839,898</u></u>
Postretirement benefit obligations, net of amounts currently payable		
Balance at beginning of year	26,242,720	22,933,595
Change during the period attributable to		
Benefits earned net of benefits paid	181,499	74,948
Actuarial experience loss (gain)	568,853	1,088,863
Changes in assumptions	<u>1,351,043</u>	<u>2,145,314</u>
Balance at end of year	<u><u>28,344,115</u></u>	<u><u>26,242,720</u></u>
Total benefit obligations	<u><u>\$ 33,374,343</u></u>	<u><u>\$ 30,582,850</u></u>

See accompanying notes to financial statements.



SERVICE EMPLOYEES INTERNATIONAL UNION HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

NOTE 1. DESCRIPTION OF THE PLAN

The following description of the Service Employees International Union Health and Welfare Fund (the Plan) provides only general information. Participants should refer to the Plan agreement for a complete description of the Plan's provisions.

General - The Plan was formed in 1968 under an agreement between employers and the labor union for the purpose of coordinating and managing healthcare benefits for member employees. The Plan is operated in accordance with the Taft-Hartley Act. The Plan is administrated by a joint board of trustees with equal union and nonunion employer representation.

To receive benefits, Plan participants must meet certain eligibility requirements. Contributions to the Plan are made by the employers at rates specified in the collective bargaining agreements. The Plan provides a comprehensive schedule of health care benefits including medical, dental, vision, life insurance, accidental death and dismemberment coverage, and prescription drug benefits to eligible participants depending upon the benefits and rates of contributions agreed to in the collective bargaining agreements. The Plan uses a preferred provider organization to help reduce healthcare costs. Life insurance, accidental death and dismemberment benefits, and stop-loss coverage is provided by insurance coverage. All other benefits are self-insured by the Plan. The Plan also provides continuation of certain benefits upon termination of employment through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Stop-Loss Coverage - The Plan has entered into a stop-loss coverage insurance arrangement in an effort to limit its exposure for self-insured benefits (individual participant claims over a specific dollar amount, as well as its aggregate exposure for all claims).

Self-Funded Benefits - The claims for self-funded benefits are processed by the Plan's third-party claims processors under administrative services only arrangements. The claims processors pay claims directly to or on behalf of participants and are then reimbursed by the Plan. Despite the Plan's utilization of third-party claims processors, ultimate responsibility for payments to providers and participants is retained by the Plan.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Method of Accounting - The financial statements have been prepared using the accrual basis of accounting. Under this basis, revenue is recognized when earned and expenses are recognized when incurred.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Investment Valuation and Income Recognition - Investments are carried at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Board of Trustees (Trustees) determines the Plan's valuation policies utilizing information provided by the investment advisers and custodians. See Note 5 for a discussion of fair value measurements.

Purchases and sales of securities are recognized on a trade-date basis. Interest income is recognized on the accrual basis. Dividends are recognized on the ex-dividend date. Net appreciation (depreciation) includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Benefit Obligations Claims Incurred but Not Reported - This benefit obligation is estimated by the Plan's actuary in accordance with accepted actuarial principles. The Trustees receive the independent actuarial and consulting firm's report and implements the recording of these obligations. The statements of benefit obligations include the actuarial estimate of claims payable, claims incurred but not reported, accumulated eligibility credit obligations, and postretirement benefit obligations which are expected to be funded by future contributions and earnings on investments.

Accumulated Eligibility Benefit Obligation - Once an employee has established initial eligibility, eligibility credits for future months may be earned and accumulated in addition to the current month's eligibility coverage. The eligibility credits are earned based upon the hours worked by a participant. The benefit obligation at the end of the year which is reported for the provision of benefits based on participants' accumulated eligibility credits has been calculated by multiplying the total number of months of coverage represented by participants' accumulated eligibility credits at the end of the year, by the average monthly amount of benefits paid per eligible participant, which was calculated by the Plan's actuary. Furthermore, the benefit obligation is reported at its estimated present value based on assumptions regarding usage of the accumulated eligibility credits and projected increases in medical costs.

Postretirement Benefit Obligations - The postretirement benefit obligation (see Note 7) represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered to December 31, 2024. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with their employer. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Administrative Expenses - The Plan's expenses are paid by the Plan and are recognized as deductions in the accompanying statements of changes in net assets available for benefits. In addition, certain investment related expenses are included in net appreciation of fair value of investments presented in the accompanying statements of changes in net assets available for benefits.

Employer Contributions Receivable and Deferred - Contributions receivable are stated at the amount management expects to collect from balances outstanding at year end. Based on a review of historical losses, current economic conditions and supportable and reasonable forecast assumptions, management has established an allowance for credit losses of \$1,666,354 and \$1,820,117 at December 31, 2024 and 2023, respectively.

The Plan writes off receivables when they are deemed uncollectable. If any recoveries are made from any accounts previously written off, they will be recognized in income or as an offset to credit loss expense in the year of recovery, in accordance with the plan's accounting policy election.

Contributions received in advance are recognized as deferred contribution income.

Use of Estimates - The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations, and changes therein, claims incurred but not reported, eligibility credits, claims payable, and disclosure of contingent assets and liabilities. Actual results could vary from these estimates.

Payment of Benefits - Benefit payments to participants are recognized upon distribution.

NOTE 3. TAX STATUS

The Plan is intended to qualify under Section 501(c)(9) of the Internal Revenue Code (IRC) and, therefore, is not subject to income tax. The Plan obtained a favorable tax determination letter from the Internal Revenue Service (IRS) on February 2, 1990, stating that the Plan, as then designed, was in compliance with the applicable requirements of the IRC. The Plan has been amended since receiving the determination letter. The Plan's Trustees believe that the Plan, as amended, continues to qualify and to operate in accordance with applicable provisions of the IRC. Therefore, no provision for income tax has been included in the Plan's financial statements.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

NOTE 4. PREMIUMS PAID TO INSURANCE COMPANIES

The Plan is insured through the Amalgamated Life for life insurance benefits and accidental death and dismemberment benefits. The accompanying statements of changes in net assets available for benefits for the years ended December 31, 2024 and 2023 include premiums paid to Amalgamated Life totaling \$73,239 and \$57,569, respectively.

For the years ended December 31, 2024 and 2023, the Plan maintained stop-loss insurance. The accompanying statements of changes in net assets available for benefits include premiums paid totaling \$491,898 and \$271,902 for the years ended December 31, 2024 and 2023, respectively.

The Plan uses preferred provider organizations (PPOs) and health maintenance organizations (HMOs) to help reduce health care costs. The accompanying statements of changes in net assets available for benefits for the years ended December 31, 2024 and 2023 include premiums paid to PPOs and HMOs totaling \$2,361,659 and \$2,264,518, respectively.

NOTE 5. INVESTMENTS AND FAIR VALUE MEASUREMENTS

Accounting standards provide the framework for measuring fair value which provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets (Level 1) and the lowest priority to unobservable inputs (Level 3).

The three levels of the fair value hierarchy are described as follows:

Level 1 Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2 Inputs to the valuation methodology include other significant observable inputs including:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability; and
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

NOTE 5. INVESTMENTS AND FAIR VALUE MEASUREMENTS (CONTINUED)

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

Following are descriptions of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2024 and 2023.

Short-term investments: Valued at cost which approximates fair value.

U.S. Government and agencies obligations: Valued using pricing models maximizing the use of observable inputs for similar securities.

Corporate bonds: Valued using pricing models maximizing the use of observable inputs for similar securities. This includes basing value on yields currently available on comparable securities of issuers with similar credit ratings. When quoted prices are not available for identical or similar bonds, the bond is valued under a discounted cash flows approach that maximizes observable inputs, such as current yields of similar instruments, but includes adjustments for certain risks that may not be observable, such as credit and liquidity risks or a broker quote if available.

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2024 and 2023:

	Assets at Fair Value as of December 31, 2024			
	Total	Level 1	Level 2	Level 3
Short-term investments	\$ 895,355	\$ -	\$ 895,355	\$ -
U.S. Government and agencies obligations	16,432,262	6,131,029	10,301,233	-
Corporate bonds	1,737,127	-	1,737,127	-
Total assets in the fair value hierarchy	19,064,744	\$ 6,131,029	\$ 12,933,715	\$ -
Investments measured at net asset value (NAV)*	18,167,788			
Investments at fair value	\$ 37,232,532			
Assets at Fair Value as of December 31, 2023				
	Total	Level 1	Level 2	Level 3
Short-term investments	\$ 109,380	\$ -	\$ 109,380	\$ -
U.S. Government and agencies obligations	20,583,705	9,110,518	11,473,187	-
Corporate bonds	2,718,683	-	2,718,683	-
Total assets in the fair value hierarchy	23,411,768	\$ 9,110,518	\$ 14,301,250	\$ -
Investments measured at net asset value (NAV)*	10,121,112			
Investments at fair value	\$ 33,532,880			

* In accordance with Accounting Standards Codification, investments that were measured at NAV per share (or its equivalent) have not been classified in the fair value hierarchy. The fair value amounts presented in these tables are intended to permit reconciliation of the fair value hierarchy to the line items presented in the statements of net assets available for benefits.

NOTE 5. INVESTMENTS AND FAIR VALUE MEASUREMENTS (CONTINUED)

Fair Value of Investments that Calculate Net Asset Value

The following tables summarize investments measured at fair value based on NAV per share as of December 31, 2024 and 2023.

Description	2024	Unfunded Commitments	Redemption Frequency (if currently eligible)	Redemption Notice Period
	Fair Value			
Common collective trusts	\$ 7,315,619	\$ -	Daily, monthly	30 Days
Limited partnerships	<u>10,852,169</u>	-	Daily, monthly	30 Days
	<u>\$ 18,167,788</u>			

Description	2023	Unfunded Commitments	Redemption Frequency (if currently eligible)	Redemption Notice Period
	Fair Value			
Common collective trusts	\$ 7,195,381	\$ -	Daily, monthly	30 Days
Limited partnerships	<u>2,925,731</u>	-	Daily, monthly	30 Days
	<u>\$ 10,121,112</u>			

The Plan's investment in the common collective trusts are valued at the NAV of units of a collective trust or fund. The NAV, as provided by the trustee, is used as a practical expedient to estimate fair value. The NAV is based on the fair value of the underlying investments held by the Plan less its liabilities. This practical expedient is not used when it is determined to be probable that the Plan will sell the investment for an amount different than the reported NAV. Participant transactions (purchased and sales) may occur daily. Were the Plan to initiate a full redemption of the trust or fund, the investment adviser reserves the right to temporarily delay withdrawal from the trust in order to ensure that securities liquidations will be carried out in an orderly business manner. Underlying assets in these funds primarily include publicly traded equity securities and fixed income securities.

The fair values of limited partnerships recorded by the Plan are determined from financial statements received by the Plan from the limited partnerships in which the Plan has invested. These financial statements are financial statements audited by independent accountants other than the Plan's independent auditors. The entities in which the Plan invests prepare their financial statements stating their investments at fair value as determined in good faith by the general partner or by a third-party valuator based on the best information available, in the absence of readily ascertainable market values. These investments are subject to various restrictions on redemption and frequency.

NOTE 6. PRIORITIES UPON TERMINATION

It is the intent of the Trustees to continue the Plan in full force and effect, however, to safeguard against any unforeseen circumstances, the Trustees reserve the right to discontinue the Plan. In the event of termination, the Trustees shall first satisfy or make provisions to satisfy the obligations of the Plan. Any remaining Plan assets will be distributed in such manner as will, in the opinion of the Trustees, carry out the purpose of the Plan. Termination shall not permit any part of the Plan's assets to be used for or diverted to purposes other than the exclusive benefit of the participants.

NOTE 7. BENEFIT OBLIGATIONS

During 2005, a retiree health benefit plan was adopted for Office and Professional Employees International Union Local 2 bargaining unit members. Certain National Officers, International Vice Presidents, and Executive Board members are also eligible for postretirement benefits. Accordingly, the 2024 and 2023 financial statements present a postretirement benefit obligation.

The actuarial present value of the expected postretirement benefit obligations was determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death or disability) between the valuation date and the expected dates of payment.

Health costs incurred by participants and their beneficiaries and dependents are primarily self-insured by the Plan. It is the present intention of the Plan to continue providing benefits. Insurance premiums for future years in respect of the Plan's postretirement benefit obligation will be funded by employer contributions to the Plan in those later years. The health care cost-trend rate assumption has a significant effect on the amounts reported. If the assumed rates increased by one percentage point in each year, that would increase the obligation as of December 31, 2024 and 2023 by \$3,933,113 and \$3,803,730, respectively.

For measurement purposes, the following were significant assumptions used in the valuations as of December 31, 2024 and 2023.

Discount rate: 5.50% in 2024; 4.80% in 2023.

Mortality rates: For 2024: 99% of the PRI-2012 Blue Collar Headcount-Weighted Mortality Table (separate employee and annuitant tables) projected generationally with the SSA-2025 improvement scale. For 2023: 99% of the PRI-2012 Blue Collar Headcount-Weighted Mortality Table (separate employee and annuitant tables) projected generationally with the MP-2021 improvement scale.



NOTE 7. BENEFIT OBLIGATIONS (CONTINUED)

Health trend rates:

Medical:	For 2024: 7.00% graded to 4.50% by 0.25% per year, for 2023: 7.00% graded to 4.50% by 0.25% per year.
Dental and vision:	3.0% in 2024 and 2023.
Prescription drug:	For 2024: 12.00% graded to 4.50% by 0.50% per year, for 2023: 10.00% graded to 4.50% by 0.25% per year.
Part D subsidy:	4.5% in 2024 and 2023.
Administrative expenses increase rate:	2.75% in 2024 and 2023.

Assumption changes since prior valuation:

- The discount rate was decreased from 4.80% to 5.50%.
- The trend rates on medical, prescription drug, and administrative costs were increased.
- The mortality improvement scale was changed from MP-2021 to SSA-2025.

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligation.

NOTE 8. RELATED PARTY AND PARTY-IN-INTEREST TRANSACTIONS

The Plan has been allocated its share of salaries, payroll taxes, employee benefits and other administrative expenses paid by the SEIU National Industry Pension Plan - United States, an organization related to the Plan through common trustees.

The Plan's share of these expenses for the years ended December 31, 2024 and 2023 was \$1,492,707 and \$1,593,460, respectively.

At December 31, 2024 and 2023, the Plan was owed \$50,416 and \$97,251, respectively, and the Plan owed \$136,618 and \$145,826, respectively, to related parties.

As disclosed in Note 2, the Plan pays certain administrative, investment and professional fees to various service providers. These transactions qualify as party-in-interest transactions, which are exempt from the prohibited transaction rules of the Employee Retirement Income Security Act of 1974 (ERISA).

NOTE 9. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 at December 31, 2024 and 2023:

	2024	2023
Net assets available for benefits per the financial statements	\$ 43,167,193	\$ 37,117,300
Benefit obligations currently payable	(585,120)	(500,232)
Claims incurred by not reported	<u>(4,410,880)</u>	<u>(3,807,868)</u>
Net assets available for benefits per the Form 5500	<u>\$ 38,171,193</u>	<u>\$ 32,809,200</u>

The following is a reconciliation of benefits paid to participants per the financial statements to the Form 5500 at December 31, 2024:

Benefits paid to or for participants, beneficiaries, and dependents per the financial statements	\$ 49,555,404
Add: amounts currently payable at end of year	585,120
Less: amounts currently payable at beginning of year	(500,232)
Add: claims incurred but not reported at end of year	4,410,880
Less: claims incurred but not reported at beginning of year	<u>(3,807,868)</u>
Benefits paid to or for participants, beneficiaries, and dependents per the Form 5500	<u>\$ 50,243,304</u>

Claims and premiums that have been processed and approved for payment at year-end, but not paid and claims incurred but not reported are not considered liabilities under U.S. generally accepted accounting principles and, therefore, are not presented as liabilities or claims and premiums paid in the accompanying financial statements but are recorded on the Form 5500 as a liability.

A reconciliation for additions per the financial statements to income per Form 5500 for the year ended December 31, 2024:

Additions per financial statements	\$ 62,223,003
Add: investment expenses	<u>96,471</u>
Income per Form 5500	<u>\$ 62,319,474</u>

A reconciliation for deductions per the financial statements to expenses per Form 5500 for the year ended December 31, 2024:

Deductions per financial statements	\$ 56,173,110
Add: investment expenses	96,471
Less: change in benefit obligations	<u>687,900</u>
Expenses per Form 5500	<u>\$ 56,957,481</u>

Investment expenses are netted with investment income on the statements of net assets available for benefits but are not netted with additions on the Form 5500.

NOTE 10. HEALTH REIMBURSEMENT ACCOUNTS

A health reimbursement arrangement was initiated in July 2006 for manager retirees who qualify with 30 years of service. The individual accounts are initially established with \$15,000 from the employer, out of which payments will be made according to rules established by the federal government to reimburse the individuals for health claims or COBRA coverage upon retirement.

In each of four subsequent years, on an annual basis, the employer will contribute an additional \$5,000 per person.

Contributions and expenses for the year ended December 31, 2024 were \$-0- and \$37,582, respectively. Contributions and expenses for the year ended December 31, 2023 were \$70,000 and \$43,641, respectively.

At December 31, 2024 and 2023, these accounts amounted to a total liability balance of \$147,397 and \$184,980, respectively.

NOTE 11. UNINSURED CASH AND CASH EQUIVALENTS

The Plan maintains its cash accounts in bank deposit accounts. Total cash balances are insured by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000 per bank. At various times throughout the year, the balances may exceed the FDIC limit. The Plan continually reviews credit concentrations as part of its asset and liability management. The Plan has not experienced any losses in its cash accounts.

NOTE 12. RISKS AND UNCERTAINTIES

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits. The actuarial present value of benefit obligations is reported based on certain assumptions pertaining to interest rates, health care inflation rates, and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near-term would be material to the financial statements.

NOTE 13. ALLOWANCE FOR CREDIT LOSSES ROLLFORWARD DISCLOSURE

Changes in the allowance for credit losses for the years ended December 31, 2024 and 2023 were as follows:

	2024	2023
Allowance for credit losses, beginning of year	\$ 1,820,117	1,293,104
Additions (charges to expenses)	11,644	562,456
Deductions (write-offs net of recoveries)	<u>(165,407)</u>	<u>(35,443)</u>
Allowance for credit losses, end of year	<u><u>\$ 1,666,354</u></u>	<u><u>\$ 1,820,117</u></u>

NOTE 14. SUBSEQUENT EVENTS

Subsequent events have been evaluated through September 26, 2025, which is the date the financial statements were available to be issued. This review and evaluation revealed no material event or transaction which would require an adjustment to or disclosure in the accompanying financial statements.



SUPPLEMENTAL INFORMATION



SERVICE EMPLOYEES INTERNATIONAL UNION HEALTH AND WELFARE FUND

SCHEDULES OF ADMINISTRATIVE EXPENSES

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
Administrative expenses		
Administrative fees and services	\$ 58,477	\$ 72,999
Administrative services	942,516	933,607
Bank charges	31,325	25,713
Equipment rental and expense	2,805	3,302
Insurance and bonding	32,676	34,685
Occupancy expenses	80,523	77,471
Office supplies and expense	5,838	5,775
Postage	34,382	41,853
Printing	16,620	59,445
Telephone	5,797	9,342
Total administrative expenses	<u>1,210,959</u>	<u>1,264,192</u>
Professional and outside service fees		
Accounting fees and expenses	31,000	31,000
Actuarial consulting and related fees	269,341	475,168
Administration fees	1,585,943	1,914,164
Consulting - other	21,938	7,339
Legal fees and expenses	55,822	46,463
Outside services	125,931	51,522
Trustee meeting expenses	36,083	7,910
Total professional and outside service fees	<u>2,126,058</u>	<u>2,533,566</u>
Computer services		
Data processing services and systems implementation	255,534	220,570
Supplies	1,142	11,185
Technical support	15,256	14,831
Total computer services	<u>271,932</u>	<u>246,586</u>
Total	<u><u>\$ 3,608,949</u></u>	<u><u>\$ 4,044,344</u></u>



SERVICE EMPLOYEES INTERNATIONAL UNION HEALTH AND WELFARE FUND

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

DECEMBER 31, 2024

Form 5500, Schedule H, Line 4i

EIN: 52-0904354
Plan No. 501

(c) Description of investment, including maturity date, rate of interest, par/maturity value or shares							
(a)	(b)	Description	Maturity Date	Rate of Interest	Par/Maturity Value or Shares	(d)	(e)
<u>Short-term Investments</u>							
JP MORGAN TR II US GVT MM INST	N/A	N/A	N/A	38,616	\$ 38,616	\$ 38,616	
JP MORGAN PRIME MONEY MARKET FUND	N/A	N/A	N/A	856,396	<u>856,739</u>	<u>856,739</u>	
Total short-term investments					<u>895,355</u>	<u>895,355</u>	
<u>U.S. Government and Agencies Obligations</u>							
U.S. TREASURY BONDS	Bonds	5/15/2046	2.500%	1,400,000	1,053,535	953,316	
U.S. TREASURY NOTES	Notes	8/15/2031	1.250%	1,215,000	1,009,589	991,537	
U.S. TREASURY NOTES	Notes	2/15/2033	3.500%	880,000	822,678	818,655	
U.S. TREASURY NOTES	Notes	8/15/2041	3.750%	530,000	513,220	466,230	
U.S. TREASURY NOTES	Notes	2/15/2034	4.000%	820,000	827,636	785,035	
U.S. TREASURY NOTES	Notes	2/15/2032	1.875%	2,705,000	2,346,799	2,275,148	
U.S. TREASURY NOTES	Notes	2/15/2045	2.500%	1,145,000	892,584	794,424	
FHLMC POOL #SD-8221	Bonds	6/1/2052	3.500%	1,424,903	1,299,556	1,262,598	
FHLMC POOL #SD-8255	Bonds	10/1/2052	3.500%	1,099,092	994,507	973,040	
FHLMC POOL #SD-8226	Bonds	10/1/2052	4.000%	1,323,280	1,243,056	1,211,421	
FHLMC UMBS POOL #RA-5275	Bonds	5/1/2051	2.500%	814,120	658,165	667,069	
FHLMC UMBS POOL #RA-4730	Bonds	9/1/2052	3.000%	734,594	612,812	624,864	
FNMA UMBS POOL #MA4599	Bonds	5/1/2052	3.000%	1,828,363	1,605,140	1,556,679	
FNMA UMBS POOL #MA4782	Bonds	10/1/2052	3.500%	1,101,168	996,385	975,050	
FNMA POOL #MA4579	Bonds	4/1/2052	3.000%	1,806,552	1,586,222	1,537,545	
FNMA POOL #FS6854	Bonds	4/1/2052	1.500%	729,410	<u>527,796</u>	<u>539,651</u>	
Total U.S. Government and Agencies Obligations					<u>16,989,680</u>	<u>16,432,262</u>	
<u>Corporate Bonds</u>							
COMCAST CORP	Bonds	4/1/2030	3.400%	445,000	409,907	412,916	
FLORIDA PWR & LT	Bonds	8/1/2034	5.000%	350,000	349,864	347,760	
IBM CORP	Bonds	3/15/2029	3.500%	285,000	265,649	270,075	
JP MORGAN CHASE & CO	Bonds	10/15/2030	2.739%	315,000	273,039	283,758	
MORGAN STANLEY FT RT	Bonds	4/1/2031	Floating	455,000	<u>411,679</u>	<u>422,618</u>	
Total corporate bonds					<u>1,710,138</u>	<u>1,737,127</u>	
<u>Common Collective Trusts</u>							
BNYM AFL-CIO CF SL BROAD MARKET STOCK INDEX FUND	CCT	N/A	N/A	576,005	<u>5,378,768</u>	<u>7,315,619</u>	
Total common collective trusts					<u>5,378,768</u>	<u>7,315,619</u>	
<u>Limited Liability Partnership</u>							
ARA CORE PROPERTY FUND, LP	LP	N/A	N/A	24	3,310,427	2,858,721	
CORE PLUS FIXED INCOME LLC	LP	N/A	N/A	776,447	<u>8,000,000</u>	<u>7,993,448</u>	
Total limited liability partnerships					<u>11,310,427</u>	<u>10,852,169</u>	
Total assets (held at end of year)					<u>\$ 36,284,368</u>	<u>\$ 37,232,532</u>	

Form 5500Department of the Treasury
Internal Revenue ServiceDepartment 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**2024****This Form is Open to
Public Inspection****Part I Annual Report Identification Information**For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)

B This return/report is: a single-employer plan a DFE (specify) _____
 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-bargained plan, check here ►

D Check box if filing under: Form 5558 automatic extension the DFVC program
 special extension (enter description) _____

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here ►

Part II Basic Plan Information - enter all requested information

1a Name of plan SEIU HEALTH AND WELFARE FUND	1b Three-digit plan number (PN) ► 501
1c Effective date of plan 05/01/1969	
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) SEIU HEALTH AND WELFARE FUND WELFARE FUND C/O TSEGAW MENGISTU 1800 MASSACHUSETTS AVE., NW, WASHINGTON DC 20036	2b Employer Identification Number (EIN) 52-0904354
2c Plan Sponsor's telephone number (202) 730-7511	
2d Business code (see instructions) 561790	

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		09/18/25	MEGAN SWEENEY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		09/18/25	MEGAN SWEENEY
	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.

Form 5500 (2024)
v. 240311

3a Plan administrator's name and address <input checked="" 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:	4b EIN
a Sponsor's name	4d PN
c Plan Name	

5 Total number of participants at the beginning of the plan year	5	4,913
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)	4,913
a(2) Total number of active participants at the end of the plan year	6a(2)	5,110
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	5,110
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f Total. Add lines 6d and 6e	6f	
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)	
(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)	
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	121

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:

4A 4B 4D 4E 4Q 4U

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input checked="" type="checkbox"/> Insurance	(1) <input checked="" 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 checked="" type="checkbox"/> Trust	(3) <input checked="" type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> General assets of the sponsor

10 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

- (1) **R** (Retirement Plan Information)
- (2) **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4) **DCG** (Individual Plan Information) - Number Attached _____
- (5) **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- (1) **H** (Financial Information)
- (2) **I** (Financial Information - Small Plan)
- (3) **A** (Insurance Information) - Number Attached 6
- (4) **C** (Service Provider Information)
- (5) **D** (DFE/Participating Plan Information)
- (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.) 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 2024 Form M-1 annual report. If the plan was not required to file the 2024 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 _____



SERVICE EMPLOYEES INTERNATIONAL UNION HEALTH AND WELFARE FUND

SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED DECEMBER 31, 2024

Form 5500, Schedule H, Line 4j

EIN: 52-0904354
Plan No. 501

(a) Identity of Party Involved	(b) Description of asset (include interest rate and maturity in case of a loan)	(c) Purchase Price	(d) Selling Price	(g) Cost of Asset	(h) Current Value of Asset on Transaction Date	(i) Net Gain or (Loss)
N/A	JP MORGAN TR II US GVT MM INST	\$ 3,796,964	N/A	\$ 3,796,964	\$ 3,796,964	\$ -
N/A	JP MORGAN TR II US GVT MM INST	-	\$ 3,840,057	3,840,057	3,840,057	-
N/A	JP MORGAN PRIME MONEY MARKET FUND	2,852,499	N/A	2,852,499	2,852,499	-
N/A	JP MORGAN PRIME MONEY MARKET FUND	N/A	2,000,000	1,999,985	1,999,985	15
N/A	FHMLC UMBS POOL #RA-7386	-	1,841,216	1,860,766	1,860,766	(19,550)