

**Form 5500**Department 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. 1510-0110  
1510-0069**2018****This Form is Open to Public Inspection****Part I Annual Report Identification Information**For calendar plan year 2018 or fiscal plan year beginning **10/01/2018** and ending **09/30/2019**

- A** This return/report is for:  a multiemployer plan  a multiple-employer plan (filers checking this box must attach a list of participating employer information in accordance with the form instr.)
- 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) \_\_\_\_\_


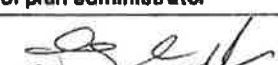
**Part II Basic Plan Information - enter all requested information****1a** Name of plan**NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION****1b** Three-digitplan number (PN) ▶ **001****1c** Effective date of plan**04/11/1958****2a** Plan sponsor's name (employer, if for a single-employer plan)

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)

**NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F****2b** Employer Identification Number (EIN)**\*\*-\*\*\*2430****2c** Plan Sponsor's telephone number**781-345-4400****2d** Business code (see instructions)**484120****1 WALL STREET****BURLINGTON****MA 01803-4768****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

<b>SIGN HERE</b>		<b>7/8/2020</b>	<b>SEAN OBRIEN (UNION TRUSTEE)</b>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>		<b>7/8/2020</b>	<b>FRANK KELLER (EMPLOYER TRUSTEE)</b>
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2018)  
v. 171027

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

<b>4</b> 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:	<b>4b</b> EIN
<b>a</b> Sponsor's name	<b>4d</b> PN
<b>c</b> Plan Name	

<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	71909
<b>6</b> 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).		
<b>a (1)</b> Total number of active participants at the beginning of the plan year	<b>6a(1)</b>	20840
<b>a (2)</b> Total number of active participants at the end of the plan year	<b>6a(2)</b>	21975
<b>b</b> Retired or separated participants receiving benefits	<b>6b</b>	25283
<b>c</b> Other retired or separated participants entitled to future benefits	<b>6c</b>	18218
<b>d</b> Subtotal. Add lines 6a(2), 6b, and 6c	<b>6d</b>	65476
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	<b>6e</b>	7013
<b>f</b> Total. Add lines 6d and 6e	<b>6f</b>	72489
<b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	<b>6g</b>	
<b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	<b>6h</b>	392
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	<b>7</b>	372

**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:  
**1B**

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

<p><b>9a</b> Plan funding arrangement (check all that apply)</p> <p>(1) <input type="checkbox"/> Insurance</p> <p>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts</p> <p>(3) <input checked="" type="checkbox"/> Trust</p> <p>(4) <input type="checkbox"/> General assets of the sponsor</p>	<p><b>9b</b> Plan benefit arrangement (check all that apply)</p> <p>(1) <input type="checkbox"/> Insurance</p> <p>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts</p> <p>(3) <input checked="" type="checkbox"/> Trust</p> <p>(4) <input type="checkbox"/> General assets of the sponsor</p>
--	--

**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

**b General Schedules**

- (1)  **H** (Financial Information)
- (2)  **I** (Financial Information - Small Plan)
- (3)  **A** (Insurance Information)
- (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 2018 Form M-1 annual report. If the plan was not required to file the 2018 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 \_\_\_\_\_

<b>SCHEDULE C (Form 5500)</b> Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	<b>Service Provider Information</b> This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>► File as an attachment to Form 5500.</b>	OMB No. 1210-0110
		<b>2018</b>
		<b>This Form is Open to Public Inspection.</b>

For calendar plan year 2018 or fiscal plan year beginning **10/01/2018** and ending **09/30/2019**

<b>A</b> Name of plan <b>NEW ENGLAND TEAMSTERS &amp; TRUCKING INDUSTRY PENSION FUND</b>	<b>B</b> Three-digit plan number (PN) ► <b>001</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>NEW ENGLAND TEAMSTERS &amp; TRUCKING INDUSTRY PENSION F</b>	<b>D</b> Employer Identification Number (EIN) <b>** - *** 2430</b>

**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

**BBH CAPITAL PARTNER IV** **\*\* - \*\*\* 4700**  
**140 BROADWAY**  
**NEW YORK** **NY 10005**

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

**ABS ALPHA GLOBAL EQUITIES** **\*\* - \*\*\* 4028**  
**55 RAILROAD AVE**  
**GREENWICH** **CT 06830**

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

**INTERCONTINENTAL US REAL ESTATE FUN** **\*\* - \*\*\* 6306**  
**1270 SOLDER FIELD ROAD**  
**BOSTON** **MA 02135**

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

**LEVINE LEICHTMAN PTR IV** **\*\* - \*\*\* 5290**  
**335 NORTH MAPLE DRIVE**  
**BEVERLY HILLS** **CA 90210**

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

ALINDA INFRASTRUCTURE FUND II \*\* - \*\*\*2089  
 100 WEST PUTNAM AVENUE, 3RD FLOOR  
 GREENWICH CT 06830

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

ABS INVESTMENT MANAGEMENT, LLC \*\* - \*\*\*5457  
 537 STEAMBOAT RD  
 GREENWICH CT 06830

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

AQR GLOBAL RISK PREMIUM \*\* - \*\*\*2119  
 TWO GREENWICH PLAZA, 3RD FLOOR  
 GREENWICH CT 06830

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

BBH CAPITAL PARTNERS V \*\* - \*\*\*4837  
 140 BROADWAY  
 NEW YORK NY 10005

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

CRESCENT MEZZANINE PARTNERS \*\* - \*\*\*0681  
 11100 SANTA MONICA BLVD, SUITE 2000  
 LOS ANGELES CA 90025

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

ENTRUST SPECIAL OPPORTUNITIES FUND \*\* - \*\*\*4478  
 375 PARK AVENUE, 24TH FLOOR  
 NEW YORK NY 10152

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

LEVINE LEICHTMAN PTR II \*\* - \*\*\*6690  
 335 NORTH MAPLE DRIVE, SUITE 130  
 BEVERLY HILLS CA 90210

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

CRESCENT HIGH INCOME FUND \*\* - \*\*\*7411  
 11100 SANTA MONICA BLVD, SUITE 2000  
 LOS ANGELES CA 90025

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

**2018****This Form is Open to  
Public Inspection.**For calendar plan year 2018 or fiscal plan year beginning **10/01/2018** and ending **09/30/2019**

<b>A</b> Name of plan <b>NEW ENGLAND TEAMSTERS &amp; TRUCKING INDUSTRY PENSION FUND</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>001</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>NEW ENGLAND TEAMSTERS &amp; TRUCKING INDUSTRY PENSION F</b>	<b>D</b> Employer Identification Number (EIN) <b>** - *** 2430</b>

**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

**RREEF AMERICAN REIT II** **\*\* - \*\*\* 5573**  
**222 S. RIVERSIDE PLAZA**  
**CHICAGO IL 60606**

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

**OAKTREE MEZZANINE FUND VI** **\*\* - \*\*\* 4894**  
**333 SOUTH GRAND AVE, 28TH FLOOR**  
**LOS ANGELES CA 90007**

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

**ASB ALLEGIANCE REAL ESTATE FUND** **\*\* - \*\*\* 7033**  
**7501 WISCONSIN AVE, SUITE 1500W**  
**BETHESDA MD 20814**

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

**ALINDA INFRASTRUCTURE FD III** **\*\* - \*\*\* 0428**  
**100 WEST PUTNAM AVENUE, 3RD FLOOR**  
**GREENWICH CT 06830**

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

Schedule C (Form 5500) 2018

v. 180523

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

AFL-CIO BIT \*\* - \*\*\*8901  
ONE EAST PRATT STREET 5TH FLOOR EAS  
BALTIMORE MD 21202

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

BLACKSTONE REAL ESTATE PARTNER \*\* - \*\*\*8589  
345 PARK AVENUE  
NEW YORK NY 10154

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

BBH CAPITAL PARTNER III \*\* - \*\*\*8878  
140 BROADWAY  
NEW YORK NY 10005

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

MELLON INVESTMENT CORP. \*\* - \*\*\*8093  
ONE WALL STREET  
NEW YORK NY 10005

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

PRINCIPAL ENHANCED \*\* - \*\*\*8198  
711 HIGH STREET  
DES MOINES IA 50392

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

STRATEGIC PARTNERS REAL ESTATE VII \*\* - \*\*\*2597  
345 PARK AVENUE  
NEW YORK NY 10154

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

TERRACAP PARTNERS IV \*\* - \*\*\*1164  
23421 WALDEN CENTER DR., SUITE 300  
ESTERO FL 34134

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

ULLICO \*\* - \*\*\*2302  
8403 COLESVILLE RD  
SILVER SPRING MD 20910

**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a on page 1, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

SEE STATEMENT 1

MARQUETTE ASSOCIATES  
180 N LASALLE  
CHICAGO

\*\* - \*\*\*5298

IL 60601

(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	1272732.	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)

BOSTON PARTNERS  
60 EAST 42ND STREET, SUITE 1550  
NEW YORK NY 10065

\*\* - \*\*\*2744

(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 68	NE	1035187.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

STATE STREET GLOBAL ADVISORS  
BOX 5488  
BOSTON MA 02284

\*\* - \*\*\*8136

(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 18	NONE	854145.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0.	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 on page 1, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

SEE STATEMENT 1

DRIEHAUS CAPITAL MANAGEMENT

\*\*-\*\*\*4295

PO BOX 10127

CHICAGO

IL 60610

(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 68	NONE	570625.	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)

FEINBERG, CAMPBELL &amp; ZACK

\*\*-\*\*\*8936

177 MILK STREET

BOSTON

MA 02109

(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	544077.	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)

UNION INSURANCE GROUP

\*\*-\*\*\*6088

303 W ERIE ST STE310

CHICAGO

IL 60654

(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?
23 50	NONE	485204.	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"/>

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

SEE STATEMENT 1

GAMCO

\*\*-\*\*\*4521

ONE CORPORATE CENTER

RYE

NY 10580

(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 50	NONE	328463.	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)

SIERRA INVESTMENT

\*\*-\*\*\*0668

PO BOX 5727

VACAVILLE

CA 95696

(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 99	NONE	257746.	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)

MORGAN, LEWIS &amp; BOCKIUS

\*\*-\*\*\*1050

PO BOX 8500

PHILADELPHIA

PA 19178

(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	253596.	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"/>

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

SEE STATEMENT 1

CBIZ

\*\*-\*\*\*2098

1845 WALNUT STREET, 14TH FLOOR  
PHILADELPHIA PA 19103

(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	253124.	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)

STATE STREET BANK &amp; TRUST

\*\*-\*\*\*7445

200 NEW PORT AVE  
QUINCY MA 02171

(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?
25 28 99	NONE	225000.	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)

ROTHSCHILD

\*\*-\*\*\*0207

1251 AVE OF THE AMERICAS 34TH FLOOR  
NEW YORK NY 10020

(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 50	NONE	194612.	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 on page 1, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions) **SEE STATEMENT 1**

**DARCANGELO & CO., LLP** \*\*-\*\*\*0103  
**120 LOMOND CT**  
**UTICA** NY 13502

(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	176912.	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)

**ZIEGLER CAPITAL MGMT, LLC** \*\*-\*\*\*3600  
**70 WEST MADISON, SUITE 2400**  
**CHICAGO** IL 60602

(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 50	NONE	143942.	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)

**MELLON INVESTMENTS CORP** \*\*-\*\*\*8093  
**ONE WALL STREET**  
**NEW YORK** NY 10005

(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 50	NONE	100351.	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 on page 1, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

SEE STATEMENT 1

SB FERNANDES & COMPANY  
201 BIRCH KNOLL RD  
RUTLAND

\*\* - \*\*\*5474

VT 05701

(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?
49 50	NONE	86020.	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)

H5  
PO BOX 347549  
PITTSBURGH

\*\* - \*\*\*9333

PA 15251

(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	46064.	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)

BRIAN RAINVILLE  
208 WEST SAINT PAUL AVE  
CHICAGO

\*\* - \*\*\*8348

IL 60614

(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	42000.	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 on page 1, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

SEE STATEMENT 1

VERITEXT  
330 OLD COUNTRY RD SUITE 300  
MINEOLA NY 11501

\*\*-\*\*\*2569

(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	31258.	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)

ELLIOT GREENLEAF  
PO BOX 3010  
BLUE BELL PA 19422

\*\*-\*\*\*7189

(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	29779.	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)

CORNERSTONE RESEARCH, INC  
599 LEXINGTON AVE 40TH FL  
NEW YORK NY 10022

\*\*-\*\*\*2543

(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	26297.	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 on page 1, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

SEE STATEMENT 1

VINTAGE  
16 MASON AVE, UNIT 4  
NORTH ATTLEBORO MA 02760

\*\*-\*\*\*1065

(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?
49 50	NONE	26286.	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)

PJ GREEN, INC.  
100 WHITESBORO ST  
UTICA NY 13504

\*\*-\*\*\*8577

(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?
49 50	NONE	26066.	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)

CITIZENS ONE  
P.O. BOX 42113  
PROVIDENCE RI 02940

\*\*-\*\*\*0600

(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?
49 50	NONE	21910.	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 on page 1, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

SEE STATEMENT 1

**COHERENT ECONOMICS**  
**1N LASALLE ST SUITE 2900**  
**CHICAGO IL 60602**

\*\*-\*\*\*6738

(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	20904.	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)

**HAYS COMPANIES**  
**NCB-88 PO BOX 1414**  
**MINNEAPOLIS MN 55480**

\*\*-\*\*\*1007

(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	18955.	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)

**LANSAS**  
**6762 EAGLE WAY**  
**CHICAGO IL 60678**

\*\*-\*\*\*7691

(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?
49 50	NONE	14836.	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 on page 1, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

SEE STATEMENT 1

WB MASON  
59 CENTRE ST  
BROCKTON MA 02301

\*\*-\*\*\*5641

(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?
49 50	NONE	13517.	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)

THE BERWYN GROUP  
PARK CENTER  
BEACHWOOD OH 45263

\*\*-\*\*\*2337

(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?
17 50	NONE	11726.	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)

BROADVIEW NETWORKS  
PO BOX 70268  
PHILADELPHIA PA 19176-0268

\*\*-\*\*\*1082

(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?
49 50	NONE	10671.	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"/>

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(a) Enter name and EIN or address (see instructions) **SEE STATEMENT 1**  
**NEW ENGLAND INSURANCE GROUP** \*\* - \*\*\* 2222  
**200 RESERVOIR ST**  
**NEEDHAM MA 02494**

(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?
22 50	NONE	10557.	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)  
**PITNEY BOWES GLOBAL** \*\* - \*\*\* 4287  
**500 ROSS ST, STE 154-0470**  
**PITTSBURGH PA 15262-0001**

(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?
49 50	NONE	9445.	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)  
**CONNECTIVITY SYSTEMS, INC.** \*\* - \*\*\* 1794  
**1220 VALLEY FORGE RD STE 18**  
**PHOENIXVILLE PA 19460**

(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?
49 50	NONE	9253.	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"/>

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(a) Enter name and EIN or address (see instructions) **SEE STATEMENT 1**

**MACKENZIE & COMPANY LLC** \*\*-\*\*\*5260  
**1500 DISTRICT AVE.**  
**BURLINGTON MA 01803**

(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	8855.	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)

**PROXYVOTE PLUS** \*\*-\*\*\*2630  
**1200 SHERMER RD, SUITE 216**  
**NORTHBROOKE IL 60062**

(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?
49 50	NONE	8700.	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)

**AM WINS BROKERAGE** \*\*-\*\*\*7313  
**PO BOX 60343**  
**CHARLOTTE NC 28260**

(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?
22 50	NONE	8502.	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 on page 1, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions) **SEE STATEMENT 1**  
**NATIONAL COORDINATING** \*\* - \*\*\*1104  
**815 16TH STREET**  
**N.W. WASHINGTON DC 20006**

(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?
49 50	NONE	8250.	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)  
**MASS MUTUAL LIFE INSURANCE CO.** \*\* - \*\*\*0850  
**1295 STATE ST. F205**  
**SPRINGFIELD MA 01111**

(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?
23 22 50	NONE	8196.	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)  
**CORPORATE RISK ADVISORS** \*\* - \*\*\*2724  
**PO BOX 290788**  
**BOSTON MA 02129**

(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?
23 50	NONE	7889.	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 on page 1, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions) **SEE STATEMENT 1**

**AMERICAN ARBITRATION ASSOC** \*\*-\*\*\*9745  
 13727 NOEL RD STE 700  
 DALLAS TX 75240

(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	7200.	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) **\*\*-\*\*\*7184**

**ITECH**  
 27 MILL PLAIN RD, SUITE 3  
 DANBURY CT 06811

(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?
49 50	NONE	7116.	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) **\*\*-\*\*\*8020**

**XEROX CORPORATION**  
 PO BOX 827598  
 PHILADELPHIA PA 19182

(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?
36 50	NONE	6383.	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 on page 1, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

**(a) Enter name and EIN or address (see instructions)      SEE STATEMENT 1**

**VANGUARD SYSTEMS INC** **\*\* - \*\*\*3967**  
**2901 DUTTON MILL RD SUITE 220**  
**ASTON PA 19014**

(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?
49 50	NONE	6300.	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)**

**LIBERTY MUTUAL** **\*\* - \*\*\*3470**  
**PO BOX 2839**  
**NEW YORK NY 10116**

(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?
22 50	NONE	5726.	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)**

**NEW ENGLAND MECHANICAL ASSOC** **\*\* - \*\*\*8830**  
**151 EPPING RD.**  
**EXETER NH 03833**

(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?
49 50	NONE	5657.	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 on page 1, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

SEE STATEMENT 1

FLAT ROCK CREATIVE  
3 PLEASANT ST.  
MARBLEHEAD

\*\*-\*\*\*5144

MA 01945

(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?
49 50	NONE	5625.	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)

STANDISH MELLON  
DEPT 81029  
WOBURN

\*\*-\*\*\*0416

MA 01813

(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	5357.	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)

(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.

<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation

<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation

<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation

<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	



**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

**2018**

**This Form is Open to  
Public Inspection.**

For calendar plan year 2018 or fiscal plan year beginning **10/01/2018** and ending **09/30/2019**

<b>A</b> Name of plan <b>NEW ENGLAND TEAMSTERS &amp; TRUCKING INDUSTRY PENSION FU</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>001</b>
<b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500 <b>NEW ENGLAND TEAMSTERS &amp; TRUCKING INDUSTRY PENSION F</b>	<b>D</b> Employer Identification Number (EIN) <b>** - *** 2430</b>

**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: **ARISTOTLE SMALL-CAP EQUITY FUND**

**b** Name of sponsor of entity listed in (a): **ARISTOTLE CAPITAL BOSTON, LLC**

<b>c</b> EIN-PN <b>** - *** 5797 003</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>40366044.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **MID-CAP GROWTH INDEX**

**b** Name of sponsor of entity listed in (a): **STATE STREET GLOBAL ADVISOR**

<b>c</b> EIN-PN <b>** - *** 5081 006</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>118063301.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **S&P FLAGSHIP FUND**

**b** Name of sponsor of entity listed in (a): **STATE STREET GLOBAL ADVISOR**

<b>c</b> EIN-PN <b>** - *** 5081 004</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>538880279.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **MSCI ACWI EX USA NL FUND**

**b** Name of sponsor of entity listed in (a): **STATE STREET GLOBAL ADVISOR**

<b>c</b> EIN-PN <b>** - *** 7987 159</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>176346931.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **EMERGING MARKETS SMALL-CAP FUND**

**b** Name of sponsor of entity listed in (a): **STATE STREET GLOBAL ADVISOR**

<b>c</b> EIN-PN <b>** - *** 9812 001</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>63530898.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **AGGREGATE BOND INDEX NL FUND**

**b** Name of sponsor of entity listed in (a): **STATE STREET GLOBAL ADVISOR**

<b>c</b> EIN-PN <b>** - *** 5081 070</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>103028423.</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

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

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Schedule D (Form 5500) 2018  
v. 171027

**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)**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)**

(Complete as many entries as needed to report all participating plans)

<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN
<b>a</b>	Plan name	
<b>b</b>	Name of plan sponsor	<b>c</b> EIN-PN

**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

**2018**

**This Form is Open  
to Public Inspection**

For calendar plan year 2018 or fiscal plan year beginning **10/01/2018** and ending **09/30/2019**

<b>A</b> Name of plan		<b>B</b> Three-digit plan number (PN) ▶	<b>001</b>
<b>NEW ENGLAND TEAMSTERS &amp; TRUCKING INDUSTRY PENSION FU</b>			
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500		<b>D</b> Employer Identification Number (EIN)	
<b>NEW ENGLAND TEAMSTERS &amp; TRUCKING INDUSTRY PENSION F</b>		<b>** - ***2430</b>	

**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.

<b>Assets</b>		<b>(a)</b> Beginning of Year	<b>(b)</b> End of Year
<b>a</b> Total noninterest-bearing cash	<b>1a</b>	<b>56739275</b>	<b>83809771</b>
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions	<b>1b(1)</b>	<b>1677678014</b>	<b>1766376220</b>
<b>(2)</b> Participant contributions	<b>1b(2)</b>		
<b>(3)</b> Other <b>SEE STATEMENT 2</b>	<b>1b(3)</b>	<b>8456580</b>	<b>4901513</b>
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (incl. money market accounts & certificates of deposit)	<b>1c(1)</b>	<b>26651116</b>	<b>27553318</b>
<b>(2)</b> U.S. Government securities	<b>1c(2)</b>	<b>64623744</b>	<b>49733052</b>
<b>(3)</b> Corporate debt instruments (other than employer securities):			
<b>(A)</b> Preferred	<b>1c(3)(A)</b>	<b>30189483</b>	<b>13536138</b>
<b>(B)</b> All other	<b>1c(3)(B)</b>	<b>29539995</b>	<b>14971856</b>
<b>(4)</b> Corporate stocks (other than employer securities):			
<b>(A)</b> Preferred	<b>1c(4)(A)</b>	<b>495232</b>	<b>0</b>
<b>(B)</b> Common	<b>1c(4)(B)</b>	<b>278375118</b>	<b>198141844</b>
<b>(5)</b> Partnership/joint venture interests	<b>1c(5)</b>	<b>1007128315</b>	<b>900154190</b>
<b>(6)</b> Real estate (other than employer real property)	<b>1c(6)</b>	<b>147908055</b>	<b>143326426</b>
<b>(7)</b> Loans (other than to participants)	<b>1c(7)</b>	<b>2706266</b>	<b>2626975</b>
<b>(8)</b> Participant loans	<b>1c(8)</b>		
<b>(9)</b> Value of interest in common/collective trusts	<b>1c(9)</b>	<b>1063059091</b>	<b>1040215876</b>
<b>(10)</b> Value of interest in pooled separate accounts	<b>1c(10)</b>		
<b>(11)</b> Value of interest in master trust investment accounts	<b>1c(11)</b>		
<b>(12)</b> Value of interest in 103-12 investment entities	<b>1c(12)</b>		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds)	<b>1c(13)</b>		
<b>(14)</b> Value of funds held in insurance co. general account (unallocated contracts)	<b>1c(14)</b>		
<b>(15)</b> Other	<b>1c(15)</b>		

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

Schedule H (Form 5500) 2018

v. 171027

		(a) Beginning of Year	(b) End of Year
<b>1 d</b>	Employer-related investments:		
	(1) Employer securities	<b>1d(1)</b>	
	(2) Employer real property	<b>1d(2)</b>	
<b>e</b>	Buildings and other property used in plan operation	<b>1e</b>	175921
<b>f</b>	Total assets (add all amounts in lines 1a through 1e)	<b>1f</b>	4393726205
<b>Liabilities</b>			
<b>g</b>	Benefit claims payable	<b>1g</b>	
<b>h</b>	Operating payables	<b>1h</b>	931384
<b>i</b>	Acquisition indebtedness	<b>1i</b>	77637023
<b>j</b>	Other liabilities <b>SEE STATEMENT 3</b>	<b>1j</b>	21285880
<b>k</b>	Total liabilities (add all amounts in lines 1g through 1j)	<b>1k</b>	99854287
<b>Net Assets</b>			
<b>l</b>	Net assets (subtract line 1k from line 1f)	<b>1l</b>	4293871918

**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.

		(a) Amount	(b) Total
<b>Income</b>			
<b>a</b>	<b>Contributions:</b>		
	(1) Received or receivable in cash from: (A) Employers	<b>2a(1)(A)</b>	452988582
	(B) Participants	<b>2a(1)(B)</b>	
	(C) Others (including rollovers)	<b>2a(1)(C)</b>	
	(2) Noncash contributions	<b>2a(2)</b>	
	(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	<b>2a(3)</b>	452988582
<b>b</b>	<b>Earnings on investments:</b>		
	(1) Interest:		
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	<b>2b(1)(A)</b>	296029
	(B) U.S. Government securities	<b>2b(1)(B)</b>	1578072
	(C) Corporate debt instruments	<b>2b(1)(C)</b>	1330113
	(D) Loans (other than to participants)	<b>2b(1)(D)</b>	226991
	(E) Participant loans	<b>2b(1)(E)</b>	
	(F) Other	<b>2b(1)(F)</b>	24700142
	(G) Total interest. Add lines 2b(1)(A) through (F)	<b>2b(1)(G)</b>	28131347
	(2) Dividends: (A) Preferred stock	<b>2b(2)(A)</b>	13313
	(B) Common stock	<b>2b(2)(B)</b>	5260193
	(C) Registered investment company shares (e.g. mutual funds)	<b>2b(2)(C)</b>	
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	<b>2b(2)(D)</b>	5273506
	(3) Rents	<b>2b(3)</b>	
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	<b>2b(4)(A)</b>	384595087
	(B) Aggregate carrying amount (see instructions)	<b>2b(4)(B)</b>	365578410
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	<b>2b(4)(C)</b>	19016677
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	<b>2b(5)(A)</b>	
	(B) Other	<b>2b(5)(B)</b>	-20785160
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	<b>2b(5)(C)</b>	-20785160

	(a) Amount	(b) Total
<b>(6)</b> Net investment gain (loss) from common/collective trusts .....	<b>2b(6)</b>	21587968
<b>(7)</b> Net investment gain (loss) from pooled separate accounts .....	<b>2b(7)</b>	
<b>(8)</b> Net investment gain (loss) from master trust investment accounts .....	<b>2b(8)</b>	
<b>(9)</b> Net investment gain (loss) from 103-12 investment entities .....	<b>2b(9)</b>	
<b>(10)</b> Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	<b>2b(10)</b>	
<b>c</b> Other income ..... <b>SEE STATEMENT 4</b>	<b>2c</b>	81599
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total .....	<b>2d</b>	506294519

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers .....	<b>2e(1)</b>	613822434
(2) To insurance carriers for the provision of benefits .....	<b>2e(2)</b>	
(3) Other .....	<b>2e(3)</b>	
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>	613822434
<b>f</b> Corrective distributions (see instructions) .....	<b>2f</b>	
<b>g</b> Certain deemed distributions of participant loans (see instructions) .....	<b>2g</b>	
<b>h</b> Interest expense .....	<b>2h</b>	
<b>i</b> Administrative expenses: (1) Professional fees .....	<b>2i(1)</b>	1872368
(2) Contract administrator fees .....	<b>2i(2)</b>	
(3) Investment advisory and management fees .....	<b>2i(3)</b>	12762857
(4) Other ..... <b>SEE STATEMENT 5</b>	<b>2i(4)</b>	6022652
(5) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(4)</b> .....	<b>2i(5)</b>	20657877
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total .....	<b>2j</b>	634480311

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>	-128185792
<b>l</b> Transfers of assets:		
(1) To this plan .....	<b>2l(1)</b>	
(2) From this plan .....	<b>2l(2)</b>	

**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)  Unqualified (2)  Qualified (3)  Disclaimer (4)  Adverse

**b** Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)?  Yes  No

**c** Enter the name and EIN of the accountant (or accounting firm) below:  
 (1) Name: **DARCANGELO & CO., LLP** (2) EIN: **\*\* - \*\*\*0103**

**d** The opinion of an independent qualified public accountant is **not attached** because:  
 (1)  This form is filed for a CCT, PSA, 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. During the plan year:

	Yes	No	Amount
<b>a</b> 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.) .....		X	
<b>b</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.) .....		X	

		Yes	No	Amount
<b>c</b> 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.)	<b>4c</b>		X	
<b>d</b> 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.)	<b>4d</b>		X	
<b>e</b> Was this plan covered by a fidelity bond?	<b>4e</b>	X		20000000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	<b>4f</b>		X	
<b>g</b> 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?	<b>4g</b>	X		2626975
<b>h</b> 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?	<b>4h</b>		X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	<b>4i</b>	X		
<b>j</b> 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.)	<b>4j</b>		X	
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	<b>4k</b>		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?	<b>4l</b>		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	<b>4m</b>		X	
<b>n</b> 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	<b>4n</b>		X	
<b>5a</b> Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If "Yes," enter the amount of any plan assets that reverted to the employer this year		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
<b>5b</b> 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.)				
<b>5b(1)</b> Name of plan(s)	<b>5b(2)</b> EIN(s)			<b>5b(3)</b> PN(s)
<b>5c</b> If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section 4021.)? If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year		<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not determined (See instr.)
				4211682

**SCHEDULE MB  
(Form 5500)**

**Multiemployer Defined Benefit Plan and Certain  
Money Purchase Plan Actuarial Information**

OMB No. 1210-0110

**2018**

Department of the Treasury  
Internal Revenue Service  
Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

**This Form Is Open to Public Inspection**

▶ **File as an attachment to Form 5500 or 5500-SF.**

For calendar plan year 2018 or fiscal plan year beginning 10/01/2018 and ending 09/30/2019

▶ **Round off amounts to nearest dollar.**

▶ **Caution: A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.**

<b>A</b> Name of plan NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION	<b>B</b> Three-digit plan number (PN) ▶ 001
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FUND	<b>D</b> Employer Identification Number (EIN) 04-6372430

**E** Type of plan: (1)  Multiemployer Defined Benefit (2)  Money Purchase (see instructions)

**1a** Enter the valuation date: Month 10 Day 01 Year 2018

**b** Assets

(1) Current value of assets .....	<b>1b(1)</b>	2,625,479,922
(2) Actuarial value of assets for funding standard account .....	<b>1b(2)</b>	2,730,943,720

<b>c</b> (1) Accrued liability for plan using immediate gain methods .....	<b>1c(1)</b>	8,391,404,221
(2) Information for plans using spread gain methods:		
(a) Unfunded liability for methods with bases .....	<b>1c(2)(a)</b>	
(b) Accrued liability under entry age normal method .....	<b>1c(2)(b)</b>	
(c) Normal cost under entry age normal method .....	<b>1c(2)(c)</b>	
(3) Accrued liability under unit credit cost method .....	<b>1c(3)</b>	8,391,404,221

**d** Information on current liabilities of the plan:

(1) Amount excluded from current liability attributable to pre-participation service (see instructions) .....	<b>1d(1)</b>	
(2) "RPA '94" information:		
(a) Current liability .....	<b>1d(2)(a)</b>	17,632,201,614
(b) Expected increase in current liability due to benefits accruing during the plan year .....	<b>1d(2)(b)</b>	412,903,221
(c) Expected release from "RPA '94" current liability for the plan year .....	<b>1d(2)(c)</b>	624,566,179
(3) Expected plan disbursements for the plan year .....	<b>1d(3)</b>	624,566,179

**Statement by Enrolled Actuary**

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

**SIGN HERE** BRYAN M. MCCORMICK *BMM*

Signature of actuary

*04/28/2020*

Date

2007345

BRYAN M. MCCORMICK

Type or print name of actuary

Most recent enrollment number

215-587-0700

CBIZ Retirement Plan Services

Firm name

Telephone number (including area code)

1845 WALNUT STREET SUITE 1400

PHILADELPHIA PA 19103-4755

Address of the firm

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions



**2** Operational information as of beginning of this plan year:

<b>a</b> Current value of assets (see instructions) .....	<b>2a</b>	2625479922
<b>b</b> "RPA '94" current liability/participant count breakdown:	<b>(1) Number of participants</b>	<b>(2) Current liability</b>
<b>(1)</b> For retired participants and beneficiaries receiving payment .....	32269	7608920515
<b>(2)</b> For terminated vested participants .....	18989	3338418091
<b>(3)</b> For active participants:		
<b>(a)</b> Non-vested benefits .....		298440078
<b>(b)</b> Vested benefits .....		6386422930
<b>(c)</b> Total active .....	20840	6684863008
<b>(4)</b> Total .....	72098	17632201614
<b>c</b> If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage .....	<b>2c</b>	14.8900 %

**3** Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
04-01-2019	355004499	0			
10-01-2019	8545059	0			
<b>Totals ▶</b>			<b>3(b)</b>	363549558	<b>3(c)</b>
					0

**4** Information on plan status:

<b>a</b> Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3)) .....	<b>4a</b>	32.50 %
<b>b</b> Enter code to indicate plan's status (see instructions for attachment of supporting evidence of plan's status). If code is "N," go to line 5 .....	<b>4b</b>	D
<b>c</b> Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan? .....		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>d</b> If the plan is in critical status or critical and declining status, were any benefits reduced (see instructions)? .....		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>e</b> If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date .....	<b>4e</b>	
<b>f</b> If the rehabilitation plan projects emergence from critical status or critical and declining status, enter the plan year in which it is projected to emerge. If the rehabilitation plan is based on forestalling possible insolvency, enter the plan year in which insolvency is expected and check here <input checked="" type="checkbox"/> .....	<b>4f</b>	2033

**5** Actuarial cost method used as the basis for this plan year's funding standard account computations (check all that apply):

<b>a</b> <input type="checkbox"/> Attained age normal	<b>b</b> <input type="checkbox"/> Entry age normal	<b>c</b> <input checked="" type="checkbox"/> Accrued benefit (unit credit)	<b>d</b> <input type="checkbox"/> Aggregate
<b>e</b> <input type="checkbox"/> Frozen initial liability	<b>f</b> <input type="checkbox"/> Individual level premium	<b>g</b> <input type="checkbox"/> Individual aggregate	<b>h</b> <input type="checkbox"/> Shortfall
<b>i</b> <input type="checkbox"/> Other (specify):			
<b>j</b> If box h is checked, enter period of use of shortfall method .....			<b>5j</b>
<b>k</b> Has a change been made in funding method for this plan year? .....			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>l</b> If line k is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>m</b> If line k is "Yes," and line l is "No," enter the date (MM-DD-YYYY) of the ruling letter (individual or class) approving the change in funding method .....			<b>5m</b>

**6 Checklist of certain actuarial assumptions:**

<b>a</b> Interest rate for "RPA '94" current liability	<b>6a</b> 3.02 %			
<b>b</b> Rates specified in insurance or annuity contracts	Pre-retirement		Post-retirement	
	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	N/A	N/A
<b>c</b> Mortality table code for valuation purposes:				
	(1) Males		(2) Females	
<b>6c(1)</b>	A		A	
<b>6c(2)</b>	A		A	
<b>d</b> Valuation liability interest rate	8.50 %		8.50 %	
<b>e</b> Expense loading	6.1 %	N/A	%	<input checked="" type="checkbox"/> N/A
<b>f</b> Salary scale	%	<input checked="" type="checkbox"/> N/A		
<b>g</b> Estimated investment return on actuarial value of assets for year ending on the valuation date			<b>6g</b> 6.3 %	
<b>h</b> Estimated investment return on current value of assets for year ending on the valuation date			<b>6h</b> 5.8 %	

**7 New amortization bases established in the current plan year:**

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	-59222862	-6572944
4	75271703	8354150

**8 Miscellaneous information:**

**a** If a waiver of a funding deficiency has been approved for this plan year, enter the date (MM-DD-YYYY) of the ruling letter granting the approval **8a**

**b (1)** Is the plan required to provide a projection of expected benefit payments? (See the instructions.) If "Yes," attach a schedule  Yes  No

**b (2)** Is the plan required to provide a Schedule of Active Participant Data? (See the instructions.) If "Yes," attach a schedule  Yes  No

**c** Are any of the plan's amortization bases operating under an extension of time under section 412(e) (as in effect prior to 2008) or section 431(d) of the Code?  Yes  No

**d** If line c is "Yes," provide the following additional information:

**(1)** Was an extension granted automatic approval under section 431(d)(1) of the Code?  Yes  No

**(2)** If line 8d(1) is "Yes," enter the number of years by which the amortization period was extended **8d(2)**

**(3)** Was an extension approved by the Internal Revenue Service under section 412(e) (as in effect prior to 2008) or 431(d)(2) of the Code?  Yes  No

**(4)** If line 8d(3) is "Yes," enter number of years by which the amortization period was extended (not including the number of years in line (2)) **8d(4)**

**(5)** If line 8d(3) is "Yes," enter the date of the ruling letter approving the extension **8d(5)**

**(6)** If line 8d(3) is "Yes," is the amortization base eligible for amortization using interest rates applicable under section 6621(b) of the Code for years beginning after 2007?  Yes  No

**e** If box 5h is checked or line 8c is "Yes," enter the difference between the minimum required contribution for the year and the minimum that would have been required without using the shortfall method or extending the amortization base(s) **8e**

**9 Funding standard account statement for this plan year:**

**Charges to funding standard account:**

<b>a</b> Prior year funding deficiency, if any	<b>9a</b>	3270575576
<b>b</b> Employer's normal cost for plan year as of valuation date	<b>9b</b>	139336417
<b>c</b> Amortization charges as of valuation date:	Outstanding balance	
	(1) All bases except funding waivers and certain bases for which the amortization period has been extended	<b>9c(1)</b>
	(2) Funding waivers	<b>9c(2)</b>
	(3) Certain bases for which the amortization period has been extended	<b>9c(3)</b>
<b>d</b> Interest as applicable on lines 9a, 9b, and 9c	<b>9d</b>	334193956
<b>e</b> Total charges. Add lines 9a through 9d	<b>9e</b>	4265887560

**Credits to funding standard account:**

<b>f</b>	Prior year credit balance, if any .....	9f	
<b>g</b>	Employer contributions. Total from column (b) of line 3 .....	9g	363549558
			Outstanding balance
<b>h</b>	Amortization credits as of valuation date .....	9h	146136852
<b>i</b>	Interest as applicable to end of plan year on lines 9f, 9g, and 9h .....	9i	29945871
			17366746
<b>j</b>	Full funding limitation (FFL) and credits:		
	(1) ERISA FFL (accrued liability FFL) .....	9j(1)	2858633377
	(2) "RPA '94" override (90% current liability FFL) .....	9j(2)	13857179191
	(3) FFL credit .....	9j(3)	
<b>k</b>	(1) Waived funding deficiency .....	9k(1)	
	(2) Other credits .....	9k(2)	
<b>l</b>	Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2) .....	9l	410862175
<b>m</b>	Credit balance: If line 9l is greater than line 9e, enter the difference .....	9m	
<b>n</b>	Funding deficiency: If line 9e is greater than line 9l, enter the difference .....	9n	3855025385
<b>9o</b>	Current year's accumulated reconciliation account:		
	(1) Due to waived funding deficiency accumulated prior to the 2018 plan year .....	9o(1)	0
	(2) Due to amortization bases extended and amortized using the interest rate under section 6621(b) of the Code:		
	(a) Reconciliation outstanding balance as of valuation date .....	9o(2)(a)	0
	(b) Reconciliation amount (line 9c(3) balance minus line 9o(2)(a)) .....	9o(2)(b)	0
	(3) Total as of valuation date .....	9o(3)	0
<b>10</b>	Contribution necessary to avoid an accumulated funding deficiency. (See instructions.) .....	10	3855025385
<b>11</b>	Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions .....		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

**SCHEDULE R  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

**Retirement Plan Information**

This schedule is required to be filed under sections 104 and 4065 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

**2018**

**This Form is Open to Public Inspection.**

For calendar plan year 2018 or fiscal plan year beginning **10/01/2018** and ending **09/30/2019**

**A** Name of plan  
**NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION FUN**

**B** Three-digit plan number (PN) ▶ **001**

**C** Plan sponsor's name as shown on line 2a of Form 5500  
**NEW ENGLAND TEAMSTERS & TRUCKING INDUSTRY PENSION F**

**D** Employer Identification Number (EIN)  
**\*\* - \*\*\*2430**

**Part I Distributions**

All references to distributions relate only to payments of benefits during the plan year.

**1** Total value of distributions paid in property other than in cash or the forms of property specified in the instructions **1** **0**

**2** Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):  
EIN(s): \_\_\_\_\_  
**Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.**

**3** Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year **3** **0**

**Part II Funding Information** (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.)

**4** Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?  Yes  No  N/A  
**If the plan is a defined benefit plan, go to line 8.**

**5** If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month \_\_\_ Day \_\_\_ Year \_\_\_  
**If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.**

**6 a** Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) **6a**  
**b** Enter the amount contributed by the employer to the plan for this plan year **6b**  
**c** Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) **6c**

**If you completed line 6c, skip lines 8 and 9.**  
**7** Will the minimum funding amount reported on line 6c be met by the funding deadline?  Yes  No  N/A

**8** If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change?  Yes  No  N/A

**Part III Amendments**

**9** If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box  Increase  Decrease  Both  No

**Part IV ESOPs** (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.

**10** Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan?  Yes  No

**11 a** Does the ESOP hold any preferred stock?  Yes  No

**b** If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.)  Yes  No

**12** Does the ESOP hold any stock that is not readily tradable on an established securities market?  Yes  No

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

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**Part V Additional Information for Multiemployer Defined Benefit Pension Plans**

**13** Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. Complete as many entries as needed to report all applicable employers.

**a** Name of contributing employer **UNITED PARCEL SERVICES**

**b** EIN **\*\* - \*\*\*7381**

**c** Dollar amount contributed by employer

**163208696.**

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box  and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month **07** Day **31** Year **2023**

**e** Contribution rate information (If more than one rate applies, check this box  and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) **6.20**

(2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify):

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box  and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box  and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify):

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box  and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box  and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify):

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box  and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box  and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify):

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box  and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box  and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify):

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box  and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box  and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify):

<b>14</b> Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:		
<b>a</b> The current year		<b>14a</b> 25592
<b>b</b> The plan year immediately preceding the current plan year		<b>14b</b> 25932
<b>c</b> The second preceding plan year		<b>14c</b> 26901
<b>15</b> Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:		
<b>a</b> The corresponding number for the plan year immediately preceding the current plan year		<b>15a</b> 98.69
<b>b</b> The corresponding number for the second preceding plan year		<b>15b</b> 96.39
<b>16</b> Information with respect to any employers who withdrew from the plan during the preceding plan year:		
<b>a</b> Enter the number of employers who withdrew during the preceding plan year		<b>16a</b> 8
<b>b</b> If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers		<b>16b</b> 37570087
<b>17</b> If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment.		<input type="checkbox"/>

**Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans**

<b>18</b> If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment		<input type="checkbox"/>
<b>19</b> If the total number of participants is 1,000 or more, complete lines (a) through (c)		
<b>a</b> Enter the percentage of plan assets held as:		
Stock:	<u>8.3</u> %	Investment-Grade Debt: <u>3.3</u> %
High-Yield Debt:	<u>.1</u> %	Real Estate: <u>6.0</u> %
Other:	<u>82.2</u> %	
<b>b</b> Provide the average duration of the combined investment-grade and high-yield debt:		
<input type="checkbox"/> 0-3 years	<input checked="" type="checkbox"/> 3-6 years	<input type="checkbox"/> 6-9 years
<input type="checkbox"/> 9-12 years	<input type="checkbox"/> 12-15 years	<input type="checkbox"/> 15-18 years
<input type="checkbox"/> 18-21 years	<input type="checkbox"/> 21 years or more	
<b>c</b> What duration measure was used to calculate line 19(b)?		
<input checked="" type="checkbox"/> Effective duration	<input type="checkbox"/> Macaulay duration	<input type="checkbox"/> Modified duration
<input type="checkbox"/> Other (specify):		

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SCHEDULE C	OTHER SERVICE PROVIDER SERVICE CODES	STATEMENT	1
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NAME	SERVICE CODES
STATE STREET GLOBAL ADVISORS	28
STATE STREET GLOBAL ADVISORS	51
STATE STREET GLOBAL ADVISORS	18
STATE STREET GLOBAL ADVISORS	19

CODES TO SCHEDULE C, LINE 2(B)

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SCHEDULE H	OTHER RECEIVABLES	STATEMENT	2
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DESCRIPTION	BEGINNING	ENDING
ACCRUED INCOME RECEIVABLE	1292695.	1112147.
RECEIVABLE FOR SECURITY SOLD	4606035.	2825583.
FOREIGN EXCHANGE RECEIVABLE	2557850.	963783.
TOTAL TO SCHEDULE H, LINE 1B(3)	8456580.	4901513.

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SCHEDULE H	OTHER PLAN LIABILITIES	STATEMENT	3
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DESCRIPTION	BEGINNING	ENDING
PAYABLE FOR SECURITY PURCHASED	18725623.	1037802.
FOREIGN EXCHANGE PAYABLE	2560257.	963658.
TOTAL TO SCHEDULE H, LINE 1J	21285880.	2001460.

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SCHEDULE H	OTHER INCOME	STATEMENT	4
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DESCRIPTION	AMOUNT
OTHER INCOME	81599.
TOTAL TO SCHEDULE H, LINE 2C	81599.

SCHEDULE H	OTHER ADMINISTRATIVE EXPENSES	STATEMENT 5
DESCRIPTION		AMOUNT
ADMINISTRATIVE EXPENSES		6022652.
TOTAL TO SCHEDULE H, LINE 2I(4)		6022652.