Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

 Complete all entries in accordance with the instructions to the Form 5500. OMB Nos. 1210-0110

2023

This Form is Open to Public Inspection

Part I	Annual Report Id	dentification Information	on				
For calenda	ar plan year 2023 or fisc	cal plan year beginning 01/0	1/2023	and ending	12/31/2023		
A This retu	urn/report is for:	a multiemployer plan		a multiple-employer plan (Filers che employer information in accordance	-		ting
a single-employer plan a DFE (specify) the first return/report the final return/report an amended return/report a short plan year return/report (less than 12 months)				·)			
C If the pla	an is a collectively-barga	ained plan, check here			▶ 🔲		
D Check b	ox if filing under:	X Form 5558 special extension (enter	description)	automatic extension	th	e DFVC program	
E If this is	a retroactively adopted	plan permitted by SECURE A	Act section 20	01, check here	▶		
Part II	Basic Plan Inform	mation—enter all requested	I information				
1a Name of plan MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURANCE TRUST				1b	Three-digit plan number (PN) ▶	501	
					1c	1c Effective date of plan 04/01/1953	
Mailing	address (include room	er, if for a single-employer pla , apt., suite no. and street, or , country, and ZIP or foreign p	P.O. Box)	f foreign, see instructions)	2b	2b Employer Identification Number (EIN) 04-1589780	
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) MASSACHUSETTS BANKERS ASSOCIATION, INC. 2c Plan Sponsor's telephone number 617-523-7595							ephone
ONE WASHINGTON MALL, 8TH FLOOR BOSTON, MA 02108 ONE WASHINGTON MALL, 8TH FLOOR BOSTON, MA 02108		2d	2d Business code (see instructions) 524290				

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.

	T	1					
SIGN	Filed with authorized/valid electronic signature.	07/30/2024	CHAD POOK				
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator				
SIGN	Filed with authorized/valid electronic signature.	07/30/2024	KATHLEEN M. MURPHY				
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor				
SIGN							
HERE	Signature of DFE	Date	Enter name of individual signing as DFE				

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

	Form 5500 (2023)	Pac	ge 2		
3a	Plan administrator's name and address X Same as Plan Sponsor			3c Adm	ninistrator's EIN ninistrator's telephone nber
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin enter the plan sponsor's name, EIN, the plan name and the plan number from Sponsor's name MASS BANKERS ASSOC GROUP INS TRUST			4b EIN	04-2628271
	Plan Name MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURA	ANCE TRUST		4d PN	501
5	Total number of participants at the beginning of the plan year			5	9982
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2) , 6b , 6c , and 6d).	(welfare plans	s complete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year			6a(1)	9982
a(2) Total number of active participants at the end of the plan year				9834
b	Retired or separated participants receiving benefits			6b	645
C	Other retired or separated participants entitled to future benefits			6c	
d	Subtotal. Add lines 6a(2) , 6b , and 6c .			6d	10479
e	Deceased participants whose beneficiaries are receiving or are entitled to			6e	
f	Total. Add lines 6d and 6e			6f	
g(Number of participants with account balances as of the beginning of the pl complete this item)			6g(1)	
g(Number of participants with account balances as of the end of the plan year complete this item)			6g(2)	
h	Number of participants who terminated employment during the plan year water than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only n		. , ,	7	
b	If the plan provides pension benefits, enter the applicable pension feature code If the plan provides welfare benefits, enter the applicable welfare feature code 4A 4D 4L	es from the Lis	st of Plan Characteristics Codes	s in the in	
Эa	Plan funding arrangement (check all that apply) (1)	(1)	nefit arrangement (check all that	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3)	insurance	contracts
	(3) X Trust	(3)	Trust		
	General assets of the sponsor	(4)	General assets of the s	ponsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are att	tached, and, v	where indicated, enter the numb	oer attach	ed. (See instructions)
а	Pension Schedules	b Genera	al Schedules		
	(1) R (Retirement Plan Information)	(1)	X H (Financial Information	1)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Information	– Small F	Plan)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3)	A (Insurance Informatio	n) – Num	ber Attached4
	actuary	(4)	X C (Service Provider Info		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	D (DFE/Participating Pla	an Informa	ation)

G (Financial Transaction Schedules)

(6)

Information) - signed by the plan actuary

DCG (Individual Plan Information) – Number Attached _

MEP (Multiple-Employer Retirement Plan Information)

(4)

(5)

Page 3

Form 5500 (2023)

Receipt Confirmation Code 143216280

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

		pursuant to	ERISA section 103(a)(2)	١.			Inspection
For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023							•
A Name of plan				B Three	e-digit		
MASSACHUSETTS BAN	IKERS ASSO	CIATION GROUP INSURANCE	TRUST	plan	number (PN	N) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (El					EIN)		
MASSACHUSETTS BAN	MASSACHUSETTS BANKERS ASSOCIATION, INC. 04-1589780						
		erning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance car BLUE CROSS/BLUE SHIE		MEDEX					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
04-1045815	53228	MULTIPLE	645		01/01/202	23	12/31/2023
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) Total amount of commissions paid (b) Total amount of fees paid							
	0 0						
3 Persons receiving comm		fees. (Complete as many entrie					
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ons or fees	were paid	
(b) Amount of sales an	d base	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose)		(e) Organization code
	(a) Name	and address of the agent, broke	er or other nerson to who	m commissi	ons or fees	were naid	
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(h) Amount of sales an	(b) Amount of sales and base Fees and other commissions paid						
commissions pai		(c) Amount		(d) Purpose)		(e) Organization code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
		Food and other commissions paid	(0)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization			
commissions paid	(c) / illioant	(4) 1 41,5000	code			
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
commissions paid			couc			
())						
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid				
(4)	no and addition of the agent, pronor	, or said, person, or memoralisms or rose note para				
(b) Amount of calca and base		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			

_						
F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year of		4		
		ent value of plan's interest under this contract in separate accounts at year er		5		
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
_	f	If contract purchased, in whole or in part, to distribute benefits from a terminal				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
	а	Type of contract: (1) deposit administration (2) immediate	te participati	on guarantee		
		(3) guaranteed investment (4) other				
		_				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•	, ,			
		(A)Tatal addition			70(6)	0
	٨	(6)Total additions			7c(6) 7d	0
		Deductions:			/ <i>1</i> u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
			7e(2)			
		(2) Administration charge made by carrier	7e(3)			
		(4) Other (specify below)	7e(4)			
		(4) Other (specify below)	70(4)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

P	art	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such core employees, the entire group of such individual contracts with each of the contracts with each of the contracts.	ntracts are exp	perience-rated as a un	it. Where con	tracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)				
	a	X Health (other than dental or vision) b Dental	С	Vision	C	Life insurance
	е	\prod Temporary disability (accident and sickness) $\left. f{f} \right. \prod$ Long-term disabi	ility g	Supplemental unem	ployment h	Prescription drug
	i	Stop loss (large deductible) j HMO contract	, s [I Indemnity contract
	m		ı			<u> </u>
	L					
9	Expe	erience-rated contracts:				
		Premiums: (1) Amount received	9a(1)		1430667	
		(2) Increase (decrease) in amount due but unpaid				
		(3) Increase (decrease) in unearned premium reserve				
		(4) Earned ((1) + (2) - (3))			9a(4)	1430667
	b	Benefit charges (1) Claims paid	9b(1)		1311182	
		(2) Increase (decrease) in claim reserves	9b(2)			
		(3) Incurred claims (add (1) and (2))			9b(3)	1311182
		(4) Claims charged			9b(4)	1322983
	С	Remainder of premium: (1) Retention charges (on an accrual basis)				
		(A) Commissions	9c(1)(A)			
		(B) Administrative service or other fees	9c(1)(B)			
		(C) Other specific acquisition costs	9c(1)(C)			
		(D) Other expenses	9c(1)(D)			
		(E) Taxes	9c(1)(E)			
		(F) Charges for risks or other contingencies	9c(1)(F)			
		(G) Other retention charges	9c(1)(G)		107684	
		(H) Total retention			9c(1)(H)	107684
		(2) Dividends or retroactive rate refunds. (These amounts were paid	in cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	e benefits afte	er retirement	9d(1)	
		(2) Claim reserves			9d(2)	
		(3) Other reserves			9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not include amount entere	ed in line 9c(2	2) .)	9e	
10	No	onexperience-rated contracts:	-			
	а	Total premiums or subscription charges paid to carrier			10a	
	b	If the carrier, service, or other organization incurred any specific costs in	connection w	rith the acquisition or		
		retention of the contract or policy, other than reported in Part I, line 2 abo			10b	
	Spe	ecify nature of costs.			<u> </u>	
P	art l	IV Provision of Information				
<u></u> 11			nlata Cahadul	Ιο Δ2	Yes	No
		d the insurance company fail to provide any information necessary to com	hiere 2cueani	I U A (100 ^	140
14	i if th	the answer to line 11 is "Yes," specify the information not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2023

					Inspection			
For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023					•			
A Name of plan				B Three	e-digit			
MASSACHUSETTS BAN	IKERS ASS	OCIATION GROUP INSURANCE	TRUST	plan	number (P	N) •	501	
C Plan sponsor's name a	s shown on I	ine 2a of Form 5500		D Employ	yer Identifi	cation Number (F	EIN)	
MASSACHUSETTS BAN	IKERS ASSO	OCIATION, INC.		04-	-1589780			
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance car NATIONAL UNION FIRE I		PITTSBURGH						
			(a) Anamarinatan			Daliayaraa	ntroot voor	
(b) EIN	(c) NAIC	` ,	(e) Approximate n persons covered a			Policy or co		
(1)	code	identification number	policy or contract		(t)) From	(g) To	
25-0687550	19445	GTP 0009101853A	7378	3	01/01/20	23	12/31/2023	
2 Insurance fee and commodescending order of the		mation. Enter the total fees and to	otal commissions paid. L	ist in line 3 t	the agents,	, brokers, and otl	her persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
	2922 0						0	
3 Persons receiving comm	missions and	I fees. (Complete as many entrie	s as needed to report all	persons).				
-	(a) Name	and address of the agent, broke	r, or other person to who	m commissi	ions or fees	s were paid		
MASS FINANCIAL SERVI	CES INS. AC		WASHINGTON MALL, TON, MA 02108-2618	8TH FLOOR	8			
(b) Amount of sales an	d base	Fe	ees and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpose)		(e) Organization code	
	2922						3	
	(a) Name	and address of the agent, broke	r, or other person to who	m commissi	ons or fees	s were paid		
	1					1		
(b) Amount of sales an			ees and other commission	•				
commissions pai	d	(c) Amount		(d) Purpose	9		(e) Organization code	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
		Food and other commissions paid	(0)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization			
commissions paid	(c) / illioant	(4) 1 41,5000	code			
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
commissions paid			couc			
())						
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid				
(4)	no and address of the agent, stener	, or said, person to mism commission or rose note para				
(b) Amount of calca and base		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			

_						
F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year of		4		
		ent value of plan's interest under this contract in separate accounts at year er		5		
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
_	f	If contract purchased, in whole or in part, to distribute benefits from a terminal				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
	а	Type of contract: (1) deposit administration (2) immediate	te participati	on guarantee		
		(3) guaranteed investment (4) other				
		_				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•	, ,			
		(A)Tatal addition			70(6)	0
	٨	(6)Total additions			7c(6) 7d	0
		Deductions:			/ <i>1</i> u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
			7e(2)			
		(2) Administration charge made by carrier	7e(3)			
		(4) Other (specify below)	7e(4)			
		(4) Other (specify below)	70(4)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

P	art l	III Welfare Benefit Contract Informa	ition				
		If more than one contract covers the same of the information may be combined for reporting	ng purposes if such con	tracts are expe	erience-rated as a uni	t. Where con	tracts cover individual
		employees, the entire group of such individu	ial contracts with each c	arrier may be	treated as a unit for p	urposes of thi	s report.
8	Ben	efit and contract type (check all applicable boxes)		_	1		- —
	а	Health (other than dental or vision)	b Dental	С	Vision	(Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabil	ity g	Supplemental unem	ployment i	Prescription drug
	iΓ	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	X Other (specify) ACCIDENTAL DEATH & DI	· 🗀	L	I		<u> </u>
	-	_					
9	Ехре	erience-rated contracts:					
	a I	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reso	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				. 9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)		T	
		(H) Total retention	_			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid i	n cash, or 📗 o	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
		Dividends or retroactive rate refunds due. (Do no	t include amount entere	d in line 9c(2)	.)	9e	
10	No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	arrier			10a	19478
	b	If the carrier, service, or other organization incurre					
	.	retention of the contract or policy, other than repo	rted in Part I, line 2 abor	ve, report amo	ount	10b	
	Spe	ecify nature of costs.					
Pa	art l	IV Provision of Information					7
11	Dic	d the insurance company fail to provide any inform	ation necessary to comp	lete Schedule	A?	Yes	No
12	If ti	he answer to line 11 is "Yes," specify the information	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

		pursuant to	ERISA section 103(a)(2)).			Inspection
For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023							
A Name of plan				B Three	e-digit	<u> </u>	
MASSACHUSETTS	BANKERS ASS	OCIATION GROUP INSURANCE	E TRUST		number (P	N) •	501
					·		
C Plan sponsor's nam	ne as shown on I	ine 2a of Form 5500		D Emplo	yer Identific	cation Number	(EIN)
MASSACHUSETTS I	BANKERS ASSO	OCIATION, INC.		04	-1589780		
		erning Insurance Contra A. Individual contracts grouped					
1 Coverage Information		<u> </u>				<u> </u>	
(a) Name of insurance	carrier	DENTAL					
	(c) NAIC	(d) Contract or	(e) Approximate no	umber of		Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
04-1045815	53228	MULTIPLE	8731		01/01/20	23	12/31/2023
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) To	(a) Total amount of commissions paid (b) Total amount of fees paid						
	0 0						
3 Persons receiving of		fees. (Complete as many entrie					
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales	s and base	F	ees and other commissio	ns paid			
commissions		(c) Amount		(d) Purpose			(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(b) Amount of sales	s and hase		ees and other commissio	ns paid			
commissions		(c) Amount		(d) Purpose			(e) Organization code

(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions paid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	T		T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	ı		.
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
• •	-		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	y ,	,	
(b) Amount of color and har-		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
	•	•	

_						
F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year of	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
_	f	If contract purchased, in whole or in part, to distribute benefits from a terminal				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
	а	Type of contract: (1) deposit administration (2) immediate	te participati	on guarantee		
		(3) guaranteed investment (4) other				
		_				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•	, ,			
		(A)Tatal addition			70(6)	0
	٨	(6)Total additions			7c(6) 7d	0
		Deductions:			/ <i>1</i> u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
			7e(2)			
		(2) Administration charge made by carrier	7e(3)			
		(4) Other (specify below)	7e(4)			
		(4) Other (specify below)	70(4)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

Р	art	≡	Welfare Benefit Contract Inform	ation						
			If more than one contract covers the same the information may be combined for report							
			employees, the entire group of such individ							
8	Ben	efit a	nd contract type (check all applicable boxes)				·	•		
_	а	_	ealth (other than dental or vision)	b X Dental	(сГ	Vision		d□	Life insurance
	е	=	emporary disability (accident and sickness)	f Long-term disabil		3	J 7	nlovment	h∏	Prescription drug
	i [op loss (large deductible)	j HMO contract		e ∟ k □	1	ipioyinciii	H	Indemnity contract
	' <u> </u>			I HIMO contract	•	<u> </u>	PPO contract		'⊔	indeninity contract
	m	Oi	ther (specify)							
0	F									
9			ce-rated contracts:		00(1)			9409092	,	
	а		iums: (1) Amount received ncrease (decrease) in amount due but unpaid		9a(1) 9a(2)			0400002	-	
			ncrease (decrease) in amount due but unpair		9a(3)				-	
			Earned ((1) + (2) - (3))					9a(4)		9409092
	b		efit charges (1) Claims paid		9b(1)			8249934		
			ncrease (decrease) in claim reserves							
		. ,	ncurred claims (add (1) and (2))					9b(3)		8249934
		(4) C	Claims charged					9b(4)		8364875
	С	Ren	nainder of premium: (1) Retention charges (c	n an accrual basis)						
			(A) Commissions		9c(1)(A	(۱				
			(B) Administrative service or other fees		9c(1)(B				_	
			(C) Other specific acquisition costs		9c(1)(C	_			_	
			(D) Other expenses		9c(1)(D	_		444007	_	
			(E) Taxes		9c(1)(E	-		111027	\dashv	
			(F) Charges for risks or other contingencies.		9c(1)(F 9c(1)(G	_		933189	-	
			(G) Other retention charges					9c(1)(H)	_	1044216
			(H) Total retention Dividends or retroactive rate refunds. (These	_	_	_			_	
	d		us of policyholder reserves at end of year: (1					9c(2)		
	u		Claim reserves	•				9d(1) 9d(2)		
		` '	Other reserves					9d(3)		
	е	` '	dends or retroactive rate refunds due. (Do n					9e		
10			erience-rated contracts:			ν-,-	,	1 00		
	а		al premiums or subscription charges paid to o	arrier				10a		
	b	If th	e carrier, service, or other organization incur	ed any specific costs in	connection	witl	h the acquisition or			
		rete	ntion of the contract or policy, other than rep					10b		
	Spe	cify r	nature of costs.							
D	art	IV	Provision of Information							
				notion nonconstrute service	oloto Coba-	ماراد		Yes	X N	
11			insurance company fail to provide any inform		nete Sched	uie	Αί	169	/\ IN	<u>, </u>
14	i it t	ne ar	nswer to line 11 is "Yes," specify the informat	on not provided. 🕨						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2023

pursuant to ERISA section 103(a)(2).						nspection					
For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023						•					
A Name of plan				B Three	e-digit						
MASSACHUSETTS BAN	NKERS ASS	OCIATION GROUP INSURANCE	TRUST	plan	number (P	N) •	501				
C Plan sponsor's name a	s shown on I	ine 2a of Form 5500		D Emplo	yer Identifi	cation Number (F	EIN)				
MASSACHUSETTS BAN	IKERS ASSO	OCIATION, INC.		04	-1589780						
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.											
1 Coverage Information:											
(a) Name of insurance car		Al									
						Dallanaaa	atus at				
(b) EIN	(c) NAIC	` '	(e) Approximate n persons covered a			Policy or co					
()	code	identification number	policy or contract		(f)) From	(g) To				
04-1045815	53228	MULTIPLE	9834	ļ.	01/01/20	23	12/31/2023				
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.											
(a) Total amount of commissions paid (b) Total amount of fees paid											
		0					0				
3 Persons receiving com	missions and	I fees. (Complete as many entries	s as needed to report all	persons).							
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	s were paid					
(b) Amount of sales an	nd base	Fe	ees and other commission	ns paid							
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code				
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	s were paid					
	•	<u> </u>				•					
(b) Amount of sales an	nd base	Fe	ees and other commission	ns paid							
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code				

(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions paid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	T		T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	ı		.
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
• •	-		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	y ,	,	
(b) Amount of color and har-		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
	•	•	

_						
F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier ma	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year of	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
_	f	If contract purchased, in whole or in part, to distribute benefits from a terminal				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
	а	Type of contract: (1) deposit administration (2) immediate	te participati	on guarantee		
		(3) guaranteed investment (4) other				
		_				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•	, ,			
		(A)Tatal addition			70(6)	0
	٨	(6)Total additions			7c(6) 7d	0
		Deductions:			/ <i>1</i> u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
			7e(2)			
		(2) Administration charge made by carrier	7e(3)			
		(4) Other (specify below)	7e(4)			
		(4) Other (specify below)	70(4)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

P	art	Welfare Benefit Contract Information If more than one contract covers the same group of er the information may be combined for reporting purpos employees, the entire group of such individual contract	es if such contract	cts are ex	perience-rated as a u	nit. Where co	ntracts cov	
8	Ben	nefit and contract type (check all applicable boxes)						
	а	X Health (other than dental or vision) Der	ntal	С	Vision		d Life i	nsurance
	е	Temporary disability (accident and sickness) f Lon	g-term disability	g	Supplemental une	mployment	h Pres	cription drug
	i İ		O contract	_	PPO contract			nnity contract
	m						Ш	•
9	Exp	perience-rated contracts:						
		Premiums: (1) Amount received		9a(1)		172755342	_	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			_	
		(3) Increase (decrease) in unearned premium reserve		9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		172755342
	b			9b(1)		166333147		
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))	<u>-</u>			. 9b(3)		166333147
		(4) Claims charged						167856796
	С	Remainder of premium: (1) Retention charges (on an accru						
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)		734350		
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)		4164196		
		(H) Total retention				. 9c(1)(H)		4898546
		(2) Dividends or retroactive rate refunds. (These amounts v	vere paid in c	ash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount h	eld to provide be	enefits afte	er retirement			
		(2) Claim reserves						
		(3) Other reserves						
	е	Dividends or retroactive rate refunds due. (Do not include a	amount entered in	n line 9c(2	2) .)			
10	No	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier				. 10a		
	b	If the carrier, service, or other organization incurred any speretention of the contract or policy, other than reported in Pai				. 10b		
	Spe	ecify nature of costs.	it i, iiile 2 above,	report an		. 105		
Р	art	IV Provision of Information						
11	Die	id the insurance company fail to provide any information nece	ssary to complet	e Schedu	le A?	Yes	X No	
		the answer to line 11 is "Yes " specify the information not prov			•		•	

Department of the Treasury Internal Revenue Service

Department 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

2023

This Form is Open to Public Inspection.

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023	and ending 12/31/2023
A Name of plan	B Three-digit
MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURANCE TRUST	plan number (PN) 501
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
MASSACHUSETTS BANKERS ASSOCIATION, INC.	04-1589780
Part I Service Provider Information (see instructions)	
You must complete this Part, in accordance with the instructions, to report the information requ \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in conne position with the plan during the plan year. If a person received only eligible indirect compensation are required to answer line 1 but are not required to include that person when completing the person wh	ection with services rendered to the plan or the person's ation for which the plan received the required disclosures,
Information on Persons Receiving Only Eligible Indirect Compensation	n
I Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this	, , , , , , , , , , , , , , , , , , ,
indirect compensation for which the plan received the required disclosures (see instructions for No	definitions and conditions)
If you answered line 1a "Yes," enter the name and EIN or address of each person providing the received only eligible indirect compensation. Complete as many entries as needed (see instruc	·
(b) Enter name and EIN or address of person who provided you disclosu	ures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosu	ures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosu	ures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosu	ures on eligible indirect compensation

Schedule C (Form 5500) 2023	Pag	e 2- 1
(h) Enter name and EIN (or address of person who provided you disc	closures on eligible indirect compensation
(b) Enter hame and Envi	n address of person who provided you disc	sidestics of engine maired compensation
(b) Enter name and EIN	or address of person who provided you disc	closures on eligible indirect compensation
(b) Enter name and EIN	or address of person who provided you disc	closures on eligible indirect compensation
(h) Enter name and FIN (or address of person who provided you disc	Placures on eligible indirect compensation
(b) Litter flame and Life	ir address or person who provided you disc	nosures on engible muneci compensation
(b) Enter name and EIN	or address of person who provided you disc	closures on eligible indirect compensation
(b) Enter name and EIN	or address of person who provided you disc	closures on eligible indirect compensation
(b) Enter name and EIN	or address of person who provided you disc	closures on eligible indirect compensation
(0) =		
(b) Enter name and EIN	or address of person who provided you disc	closures on eligible indirect compensation

	Schedule C (Form 550	00) 2023		Page 3 - 1		
answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN or	address (see instructions)		
MASS FIN	I SERVICES INS AGE	ENCY		/ASHINGTON MALL, 8TH FLO DN, MA 02108	OR	
04-268089	95					
(b) Service Code(s)	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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13	NONE	2922	Yes X No	Yes X No	523393	Yes No X
		(a) Enter name and EIN or	address (see instructions)		
SMITH &	DOWNEY			DWSONTOWN BLVD., SUITE 1 MORE, MD 21286	EAST	
52-183927	0					
(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?	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	NONE	67573	Yes No X	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
WOLF & C	COMPANY, P.C.			TATE STREET DN, MA 02109		
04-268988	3					

(b)

Service

Code(s)

10

(c)

Relationship to

employer, employee

organization, or person known to be

a party-in-interest

NONE

(d)

Enter direct

compensation paid

by the plan. If none,

enter -0-.

19350

(e)

Did service provider

receive indirect

compensation? (sources

other than plan or plan

sponsor)

Yes No X

(f)

Did indirect compensation include eligible indirect

compensation, for which the

plan received the required

disclosures?

Yes No

(g)

Enter total indirect

compensation received by

service provider excluding eligible indirect

answered "Yes" to element (f). If none, enter -0-.

compensation for which you estimated amount?

(h)

Did the service

provider give you a

formula instead of

an amount or

Yes No

Page	3 -	
------	-----	--

answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
-			(a) Enter name and EIN or	address (see instructions)		
LIBERTE	GROUP LLC			ENNSYLVANIA AVE NW, SUITINGTON, DC 20004	ΓE 600	
26-243542	23					
(b) Service Code(s)	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?	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	NONE	16256	Yes No X	Yes No		Yes No
			(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be	(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	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required	Enter total indirect compensation received by service provider excluding eligible indirect	(h) Did the service provider give you a formula instead of an amount or
	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element (f). If none, enter -0	estimated amount?
			Yes No	Yes No		Yes No
		((a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employer 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 No	Yes No		Yes No

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensatio or provides contract administrator, consulting, custodial, investment advisory, investment manage questions for (a) each source from whom the service provider received \$1,000 or more in indirect provider gave you a formula used to determine the indirect compensation instead of an amount or many entries as needed to report the required information for each source.	ment, broker, or recordkeepin compensation and (b) each so	g services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
	(GGG Methadilerie)	Somponeation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

Pa	rt II Service Providers Who Fail or Refuse to	Provide Infori	mation
4	Provide, to the extent possible, the following information for eathis Schedule.	ch service provide	er who failed or refused to provide the information necessary to complete
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Page	6 -	I
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Pa	art III	Termination Information on Accountants and Enrolled Actuaries (see in (complete as many entries as needed)	structions)
а	Name:		b EIN:
С	Positio		
d	Addres		e Telephone:
Ex	planatio	n:	
<u>a</u>	Name:		b EIN:
<u></u>	Positio		
d	Addres	SS:	e Telephone:
Fx	planatio).	
	, p.a a		
а	Name:		b EIN:
С	Positio		
d	Addres		e Telephone:
Ex	planatio	n:	
			•
<u>a</u>	Name:		b EIN:
<u>c</u> d	Position Address		O Talanhana.
u	Addres	SS:	e Telephone:
Ex	planatio	n:	
а	Name:		b EIN:
С	Positio		
d	Addres		e Telephone:
Ex	planatio	n:	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023

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.

and ending

12/31/2023

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

A Name of plan MASSACHUSETTS BANKERS ASSOCIATION GROUP INSURANCE TRUST	B Three-digit plan number (PN)) •	501		
C Plan sponsor's name as shown on line 2a of Form 5500			D Employer Identifica	ation Number (E	EIN)
MASSACHUSETTS BANKERS ASSOCIATION, INC.		04-1589780			
Part I Asset and Liability Statement				·	
1 Current value of plan assets and liabilities at the beginning and end of the plan the value of the plan's interest in a commingled fund containing the assets of n lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance benefit at a future date. Round off amounts to the nearest dollar. MTIAs, C and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. Se	more than one ce contract wh CTs, PSAs, a	plan on a nich guaran nd 103-12	line-by-line basis unless itees, during this plan ye	the value is repeat, to pay a spe	oortable on ecific dollar
Assets	1	(a) B	eginning of Year	(b) End	of Year
a Total noninterest-bearing cash	1a				
b Receivables (less allowance for doubtful accounts):					
(1) Employer contributions	1b(1)				
(2) Participant contributions	1b(2)				
(3) Other	1b(3)		300818		305743
C General investments:					
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		4735683		4748808
(2) U.S. Government securities	1c(2)				
(3) Corporate debt instruments (other than employer securities):					
(A) Preferred	1c(3)(A)				
(B) All other	1c(3)(B)				
(4) Corporate stocks (other than employer securities):					
(A) Preferred	1c(4)(A)				
(B) Common	1c(4)(B)				
(5) Partnership/joint venture interests	1c(5)				
(6) Real estate (other than employer real property)	1c(6)				
(7) Loans (other than to participants)	1c(7)				
(8) Participant loans	1c(8)				
(9) Value of interest in common/collective trusts	1c(9)				
(10) Value of interest in pooled separate accounts	1c(10)				
(11) Value of interest in master trust investment accounts	1c(11)				
(12) Value of interest in 103-12 investment entities	1c(12)				
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)				

1c(14)

1c(15)

(14) Value of funds held in insurance company general account (unallocated

(15) Other.....

contracts)

d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	5036501	5054551
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h	22917	56180
i Acquisition indebtedness	1i		
j Other liabilities	1j		15700
k Total liabilities (add all amounts in lines 1g through1j)	1k	22917	71880
Net Assets			
Net assets (subtract line 1k from line 1f)	11	5013584	4982671

Part II Income and Expense Statement

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

	Income		(a) Amount	(b) Total
а	Contributions:			
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	20704	
	(B) Participants	2a(1)(B)		
	(C) Others (including rollovers)	2a(1)(C)		
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		20704
b	Earnings on investments:			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	70266	
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	(F) Other	2b(1)(F)		
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		70266
	(2) Dividends: (A) Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)		
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)		
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

			(a) Amount	(b) Total
	(6) Net investment gain (loss) from common/collective trusts	2b(6)	(4)	(47)
	(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
	(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
	(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
	10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
С	Other income	2c		78646
d	Total income. Add all income amounts in column (b) and enter total	2d		169616
	Expenses			
е	Benefit payment and payments to provide benefits:			
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		
	(2) To insurance carriers for the provision of benefits	2e(2)	19478	
	(3) Other	2e(3)		
	(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		19478
f	Corrective distributions (see instructions)	2f		
g	Certain deemed distributions of participant loans (see instructions)	2g		
h	Interest expense	2h		
i.	Administrative expenses:			
	(1) Salaries and allowances	2i(1)		
	(2) Contract administrator fees	2i(2)	1226	
	(3) Recordkeeping fees	2i(3)		
	(4) IQPA audit fees	2i(4)		
	(5) Investment advisory and investment management fees	2i(5)		
	(6) Bank or trust company trustee/custodial fees	2i(6)		
	(7) Actuarial fees	2i(7)		
	(8) Legal fees	2i(8)	83829	
	(9) Valuation/appraisal fees	2i(9)		
	(10) Other trustee fees and expenses	2i(10)		
	(11) Other expenses	2i(11)	95996	
	(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		181051
	Total expenses. Add all expense amounts in column (b) and enter total	2j		200529
-	Net Income and Reconciliation			
k	Net income (loss). Subtract line 2j from line 2d	2k		-30913
	Transfers of assets:			
	(1) To this plan	21(1)		
	(2) From this plan	21(2)		

⊃ad	е	4

Pa	rt III	Accountant's	s Opin	ion										
3	Comple		h 3c if th	e opinion of	an indeper	ndent qualif	ied public ad	ccountant is attac	ched to	this	Form	5500. Co	omplete line 3d if an opinior	n is not
а	The atta	The attached opinion of an independent qualified public accountant for this plan is (see instructions):												
	(1)	X Unmodified	(2)	Qualified	(3)	Disclaime	er (4)	Adverse						
b	perforn	ned pursuant to bo	oth 29 Cl	FR 2520.103	8-8 and 29	CFR 2520.	103-12(d). C	Check box (3) if p	oursuar	nt to i	neither		poxes (1) and (2) if the audi	
	(1) D	OL Regulation 25	20.103-8	3 (2) DOL	Regulation	n 2520.103	3-12(d) (3)	neither DOL Re	egulatio	on 25	20.10	3-8 nor [OOL Regulation 2520.103-1	2(d).
С	Enter th	e name and EIN o	of the ac	countant (or	accounting	g firm) belo	w:							
		Name: WOLF &						. ,	EIN:	_	68988	3		
d		nion of an indeper				_								
	(1)	This form is file	ed for a	CCT, PSA, [OCG or MT	TA. (2)	It will be a	ttached to the ne	ext Forr	n 55	00 pur	suant to	29 CFR 2520.104-50.	
Pá	art IV	Compliance	Quest	ions										
4	103-1	s and PSAs do not 12 IEs also do not plete the rest of Pa	complet	e lines 4j and	d 4I. MTIAs	also do no	ot complete	line 4l. DCGs do	not co	mple	te line	s 4e, 4f,	, 4n, or 5. 4k, 4l, and 5, and DCGs ge	enerally
	Durin	g the plan year:									Yes	No	Amount	
а		there a failure to t												
	•	d described in 29 corrected. (See ins					, ,	,		4a		X		
b		any loans by the	•		0									
	secu	e of the plan year or red by participant'	s accour	nt balance. (Attach Sch	edule G (F	orm 5500) P	art I if "Yes" is		4.		X		
_		ked.)								4b				
С	unco	e any leases to whollectible? (Attach	Schedule	G (Form 55	500) Part II	if "Yes" is	checked.)		—	4c		X		
d	repo	e there any nonexorted on line 4a. Att ked.)	tach Sch	edule G (Fo	rm 5500) F	art III if "Ye	es" is			4d		X		
е	Was	this plan covered	by a fide	elity bond?						4e		Х		
f		he plan have a los	•	•					<u>⊢</u>					
	by fr	aud or dishonesty	?							4f		X		
g		he plan hold any a olished market nor								4g		X		
h		he plan receive ar	•					•						
	dete	rminable on an es	tablished	d market nor	set by an i	ndepender	nt third party	appraiser?	······ [,	4h		X		
i		he plan have asse see instructions fo			•	,	,			4i		X		
j	value	e any plan transac e of plan assets? (nstructions for for	Attach s	chedule of tr	ansactions	if "Yes" is	checked and	d		4j	Х			
k		e all the plan asse or brought under								4k		X		
ı	Has	the plan failed to p	orovide a	ıny benefit w	hen due ur	nder the pla	an?			41		X		
n	1 If this	s is an individual a 0.101-3.)	ccount p	olan, was the	re a blacko	out period?	(See instruc	ctions and 29 CF	R			X		
n	If 4m	was answered "Ye exceptions to pro	es," che	ck the "Yes"	box if you	either prov	ided the req	uired notice or or	ne	4m 4n		X		
5a	Has:	a resolution to termes," enter the amour	inate the	plan been ad	lopted durin	g the plan y	ear or any pr	ior plan year?		-	X No	1		

5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(transferred. (See instructions.)	s) to which assets or lia	bilities were
	5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)
i	Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (Substructions.) Yes for "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year	See ERISA section 402 No Not determing.	1 and ned

Schedule H (Form 5500) 2023

Page **5**-



Massachusetts Bankers Association Group Insurance Trust

Financial Statements and Supplemental Schedules

Years Ended December 31, 2023 and 2022



Massachusetts Bankers Association Group Insurance Trust

E.I.N. 04-2628271 Plan Number 501

Financial Statements and Supplemental Schedules for the Years Ended December 31, 2023 and 2022

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Independent Auditor's Report

To the Board of Trustees of the Massachusetts Bankers Association Group Insurance Trust:

Opinion

We have audited the financial statements of Massachusetts Bankers Association Group Insurance Trust (the "Trust"), which comprise the statements of net assets available for benefits as of December 31, 2023 and 2022 and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial status of the Trust as of December 31, 2023 and 2022, and the changes in its financial status for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Trust's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets (held at end of year) and reportable transactions as of or for the year ended December 31, 2023 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 (ERISA). Such information is the responsibility of management and was derived from and relates directly to the underlying

accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

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

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

Boston, Massachusetts

Wolf & Company, P.C.

May 22, 2024

Statements of Net Assets Available for Benefits

December 31, 2023 and 2022

	2023	2022
Assets		
Cash and cash equivalents	\$ 4,748,808	\$ 4,535,683
Certificates of deposit	-	200,000
Premiums receivable	8,765	10,500
Omada program receivable	52,027	32,881
Risk sharing arrangement receivable	-	105,464
Due from affiliates	244,951	140,292
Prepaid income taxes	-	10,300
Other accounts receivable		1,381
Total assets	5,054,551	5,036,501
Liabilities		
Accounts payable and accrued expenses	56,180	22,917
Income taxes payable	15,700	
Total liabilities	71,880	22,917
Net assets available for benefits	\$ 4,982,671	\$ 5,013,584

The accompanying notes are an integral part of these financial statements.

Statements of Changes in Net Assets Available for Benefits

Years Ended December 31, 2023 and 2022

	2023	2022
Additions:		
Risk sharing arrangement	\$ -	\$ 105,464
Premium income from member banks	20,704	22,762
Omada program	50,646	32,881
Interest income	70,266	3,632
Performance guarantee	28,000	11,750
Total additions	169,616	176,489
Deductions: Professional fees Omada program	103,179 50,646	22,398 32,881
Premiums paid to insurance carriers	19,478	19,011
Administrative fees paid to affiliate	1,226	3,355
Income taxes	26,000	448
Total deductions	200,529	78,093
Net change in net assets	(30,913)	98,396
Net assets available for benefits:		
Beginning of year	5,013,584	4,915,188
End of year	\$ 4,982,671	\$ 5,013,584

The accompanying notes are an integral part of these financial statements.

Notes to Financial Statements

Years Ended December 31, 2023 and 2022

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

General

The Massachusetts Bankers Association Group Insurance Trust (the "Trust") is a group insurance arrangement operated for the purpose of providing group insurance coverage to member banks' employees at costs that are generally less than those obtainable on an individual bank basis. The Trust operates the Omada Program, which offers a digital wellness program to member banks.

Trust Amendment

The Trust Agreement was amended and restated in its entirety, effective as of January 1, 2014, to update the Trust Agreement to reflect provisions to comply with the Patient Protection and Affordable Care Act ("PPACA") and the Health Care Education and Reconciliation Act, as amended, and the regulations thereunder; and to provide for the continued qualification of the Trust as a voluntary employees' beneficiary association within the meaning of Section 501(c)(9) of the Internal Revenue Code (the "Code").

Effective January 1, 2014, the Trust established The Massachusetts Bankers Association Group Insurance Plan (the "Plan") to continue the operation of the Trust's long-standing group insurance program, to formalize the role of the Trust as the sponsor and administrator of the Plan, to clarify the process by which participating member banks may adopt the Plan, and to further clarify that the Plan, as set forth herein, is intended to constitute a large employer for purposes of the PPACA, a single employee welfare benefit plan under Section 3(1) of ERISA, and a single accident or health plan under Section 105(e) of the Code.

Basis of Presentation

The accompanying financial statements have been prepared on the accrual basis of accounting.

Premium Income

Business Travel Accident insurance premium income is earned and billed annually by the Trust, based on member banks' plan design and enrollment.

Premiums for medical and dental coverage under the Trust are billed by and paid directly to the insurance companies.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and changes therein and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include money market accounts and cash balances with an original maturity of three months or less when purchased. The Trust may maintain cash and cash equivalent deposits in excess of federally insured limits at certain financial institutions. The Trust has not experienced any losses in such accounts and does not believe it is exposed to significant credit risks.

Certificates of Deposit

The Trust invests in certificates of deposit with interest income being recognized in the period earned. Due to the short-term nature of the certificates of deposit, they are stated at cost, which approximates fair value.

Due From Affiliates

Amounts due from affiliates represent amounts due from the Massachusetts Bankers Association, Inc. and Subsidiary in the normal course of performing the Trust's activities.

2. INVESTMENTS

Certificates of deposit mature as follows at December 31, 2023 and 2022:

	2023		 2022
Due in 2023	\$		\$ 200,000
Total certificates of deposit	\$		\$ 200,000

3. INSURANCE CONTRACTS

The Trust maintains a risk sharing arrangement with Blue Cross Blue Shield whereby the Trust and Blue Cross share excess medical and dental premiums, as defined, with such amounts to be determined in the following policy year. The arrangement automatically renews each year.

During 2023, the Trust did not receive any funds in connection to the 2022 policy year, in which the claim period ended on June 30, 2022. During 2022, subsequent to the claim period for the 2021 policy year, the Trust recorded risk sharing arrangement revenue of \$105,464 in connection with the 2021 dental risk sharing agreement. A receivable for the risk sharing agreement revenue of \$105,464 is recorded on the statement of net assets available for benefits as of December 31, 2022.

At December 31, 2023, the amount, if any, that the Trust will receive in 2024 in connection with the 2023 medical and dental risk sharing agreement cannot be reasonably estimated, and therefore are not determinable at December 31, 2023. As a result, the Trust has not recorded a receivable nor recognized risk sharing arrangement revenue relating to the 2023 policy year.

4. PERFORMANCE GUARANTEES

The Trust maintains agreements (the "Agreements") with insurance carriers (the "Carriers") which provide for certain administrative performance guarantees such as claim processing timeliness and accuracy, and reporting of performance levels by the Carriers. Failure by the Carriers to comply with the Agreements triggers certain fees to be paid to the Trust. During 2022, the Trust recognized performance guarantee fees of \$11,750 relating to 2021. During 2023, the Trust recognized performance guarantee fees of \$28,000 relating to 2022.

At December 31, 2023, the amount, if any, that the Trust will receive in 2024 for performance guarantee fees from the medical and dental plans relating to 2023 cannot be reasonably estimated. As a result, the Trust has not recorded a receivable nor performance guarantee revenue relating to the 2023 plan year.

5. ADMINISTRATIVE FEES

Member banks and certain third-party vendors remit some payments to the Trust for insurance premiums and administrative fees. While most premiums are paid directly to the respective insurance carriers, administrative fees are forwarded to the MBA Service Corporation and Subsidiaries (the "Corporation") (a wholly-owned subsidiary of the Massachusetts Bankers Association, Inc. (the "Association")). The administrative fees are connected with certain administrative services provided by the Association for various insurance and employee benefit programs. Administrative fees paid by the Trust to the Corporation amounted to \$1,226 and \$3,355 for 2023 and 2022, respectively.

6. BENEFIT OBLIGATIONS

Since the group insurance arrangement of the Trust is fully insured, there is no unfunded benefit obligation and, accordingly, no change in the benefit obligation for 2023 and 2022.

7. TAX STATUS

The Trust obtained its latest determination letter on February 16, 1977, in which the Internal Revenue Service stated that the Trust, as then designed, was in compliance with the applicable requirements of the Code. The Trust was most recently amended effective January 1, 2014 as indicated in Note 1 to the financial statements. Although the Trust has been amended since receiving the determination letter, the Plan Administrator and the Trust's tax counsel believe that the Trust is currently designed and being operated in compliance with the applicable requirements of the Code and therefore believe that the Trust is tax-exempt.

The Trust is a tax exempt organization as described in Section 501(c)(9) of the Code, and is generally exempt from federal taxes pursuant to Section 501(a) of the Code. However, the Trust is subject to Federal and Massachusetts income tax on unrelated business taxable income generated from investments and realized capital gains.

Tax positions taken or expected to be taken in the course of preparing the Trust's tax returns, including the position that the Trust qualifies as a tax exempt organization, are required to be evaluated to determine whether the tax positions are "more-likely-than-not" to be upheld under regulatory review. The Trust does not have any uncertain tax positions at December 31, 2023 and 2022 which require disclosure or accrual. The Trust is currently open to audit under applicable statutes of limitation by federal and state tax authorities for the years ended December 31, 2020 through 2023.

The provision for income taxes consists of the following:

	2023	2	.022
Federal State	\$ 22,500 3,500	\$	300 148
Total	\$ 26,000	\$	448

The Trust is a VEBA "Voluntary Employee Benefit Association." Income on assets not used to pay premiums is Unrelated Business Income. In 2022 there was only \$3,632 in interest income compared to \$70,266 in 2023. This caused an increase in tax expense in 2023.

8. SUBSEQUENT EVENTS

Management has evaluated subsequent events through May 22, 2024, which is the date the financial statements were available to be issued. There were no subsequent events that require adjustment to or disclosure in the financial statements.

Schedule H, Line 4i - Schedule of Assets (Held at End of Year)

E.I.N. 04-2628271

Plan Number 501

December 31, 2023

Identity of issue, borrower, lessor, or similar party	Description of investment including maturity date, rate of interest, collateral, par or maturity	Cost	Current Value
None			
There were no investment assets which were both acqui	red and disposed of during the plan year.		
See independent auditor's report.			

Schedule H, Line 4j - Schedule of Reportable Transactions

E.I.N. 04-2628271

See independent auditor's report.

Plan Number 501

Year Ended December 31, 2023

pa	Identity of urty involved	Description of asset (include interest rate and maturity in case of a loan)	Purchase price	Selling price	Lease rental	Expense incurred with transaction	Cost of asset	Current value of asset on transaction	Net gain or (loss)
Category (1)	- A single transaction in excess	of 5% of plan assets:							
Salem Five B	ank ·	-Maturity of CD, .49%, due 3/31/23		\$200,000					
	- A series of transactions with the securities and aggregating to m	he same person involving property ore than 5% of plan assets:							
None									
Category (3)	- A series of securities transacti	ons in excess of 5% of plan assets:							
None									
Category (4)	- A single transaction with the s	ame person in excess of 5% of plan assets.							
None									

Schedule H, Line 4i - Schedule of Assets (Held at End of Year)

E.I.N. 04-2628271

Plan Number 501

December 31, 2023

Identity of issue, borrower, lessor, or similar party	Description of investment including maturity date, rate of interest, collateral, par or maturity	Cost	Current Value
None			
There were no investment assets which were both acqui	red and disposed of during the plan year.		
See independent auditor's report.			

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

> Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210 - 0110 1210 - 0089

2023

	sion Benefit Guaranty Corporation		110 11100 11010113			Public In:		
Par	or calendar plan year 2023	rt Identification In		10000	42.14	4 10000		
	his return/report is for:					1/2023		
A 1	nis return/report is for:	a multiemployer p	least 1	multiple-employer plan (Filers				tting
		a single-employer	2023	mployer information in accord	lance with the	form instruction	18.)	
Вт	his return/report is:	the first return/rep		DFE (specify)				
	nis return report is.			ne final return/report	<i>a.</i>			
an amended return/report a short plan year return/report (less than 12 months) If the plan is a collectively-bargained plan, check here								
D C	heck box if filing under:	Form 5558		utomatic extension	#- 55/0	▶∐		
_	noon box ir illing artaor.		(enter description)	utomatic extension	the DFVC pro	ogram		
E If	this is a retroactively adopte	ed plan permitted by Si	FCURE Act section 20:	1 chack hare	П			
Par	II Basic Plan Inf	ormation - enter all	requested information	i, Glock Hold				_
1a N	lame of plan			14	b Three-digit			_
	SACHUSETTS BAN	KERS ASSOCI	ATION	1'	plan numb		501	
	UP INSURANCE I			1	c Effective da		301	_
				"	04/01/			
2a P	lan sponsor's name (employer,	, if for a single-employer p	lan)	2		dentification Nu	mber (FIN)	_
	Aailing address (include room, a				04-158		ilibei (Lii4)	
C	ity or town, state or province, o	country, and ZIP or foreign	postal code (if foreign, s	ee instructions)		sor's telephone i	number	
MAS	SACHUSETTS BAN	KERS ASSOCIA	ATION, INC.		L7-523-7		idiliboi	
				-		ode (see instruc	tions)	_
					524290		00.00.00 7	
ONE	WASHINGTON MA	LL, 8TH FLOO	OR					
BOS	PON	MA	02108					
				be assessed unless reasons				_
Jnder pe is the ele	naities of perjury and other penaities actronic version of this return/report, a	set forth in the instructions, I de and to the best of my knowledg	eclare that I have examined this e and belief, it is true, correct,	s return/report, including accompanying and complete.	schedules, stateme	nts and attachments,	as well	_
SIGN	Chad Pook	6	07/30/2024	CHAD POOK				SIG
HERE	Signature of plan admini		Date	Enter manne of individual at				310
	/ // /	30 4001		Enter name of individual sig		aministrator		
SIGN	Ille		7.30.24	KATHLEEN M. MU	RPHY			SIG
	Signature of employer/pl	an sponsor	Date	Enter name of individual sig	ning as employ	er or plan spon:	sor	1
SIGN	Let	2						7
HERE								
	Signature of DFE		Date	Enter name of individual sig	ning as DFE			1
or Pa	perwork Reduction Act No	tice, see the Instructi	ons for Form 5500.			Form 5	500 (2023)	_

v. 230728

	Form 5500 (2023)					Pag	ge 2			
3a	Plan administrator's name and address 🗵 Same as Plan Sponsor						rator's	EIN		
						;	3c A	dminist	rator's	telephone number
a c	If the name and/or EIN of the plan sponsor or the plan name has change enter the plan sponsor's name, EIN, the plan name and the plan number Sponsor's name MASS BANKERS ASSOC GROUP IN Plan NameMASSACHUSETTS BANKERS ASSOCIATIOUP INSURANCE TRUST	from the la	ast r	reti		-	filed fo	r this p	lan,	4b EIN 04-2628271 4d PN 501
5	Total number of participants at the beginning of the plan year								5	9,982
6	Number of participants as of the end of the plan year unless otherwise s	tated (welf	are	pla	ıns con	nplete	only li	nes		
_	6a(1), 6a(2), 6b, 6c, and 6d).								C=(4)	0 000
	(1) Total number of active participants at the beginning of the plan year								6a(1)	<u> </u>
	(2) Total number of active participants at the end of the plan year								6b	645
	Other retired or separated participants entitled to future benefits								6c	013
	Subtotal. Add lines 6a(2), 6b, and 6c								6d	10,479
	Deceased participants whose beneficiaries are receiving or are entitled to								6e	
	Total. Add lines 6d and 6e								6f	
g	(1) Number of participants with account balances as of the beginning of				-					
	plans complete this item)								6g(1)	
((2) Number of participants with account balances as of the end of the pla	•	-				-		6g(2)	
h	complete this item) Number of participants who terminated employment during the plan yea								09(2)	
•	less than 100% vested								6h	
7	Enter the total number of employers obligated to contribute to the plan (
	this item)	-	-	-	-		-		7	
8a	If the plan provides pension benefits, enter the applicable pension feature	re codes fro	om t	the	List of	f Plan	Chara	cteristic	s Code	es in the instructions:
4A	If the plan provides welfare benefits, enter the applicable welfare feature $4 D 4 L$									
9a	Plan funding arrangement (check all that apply)						ent (ch	eck all	that app	ply)
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1)	X		nsuran		410/0	\(2\ inc.	ıranaa a	ontracto
	(2) Code section 412(e)(3) insurance contracts (3) X Trust	(2) (3)	Н		Joue si Trust	ection	412(6)(3) 11150	irance c	contracts
	(4) General assets of the sponsor	(4)	Н			l asset	ts of th	ie spon	sor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules a (See instructions)		d, a							per attached.
а	Pension Schedules	b _{Gei}	nera	al S	Schedu	ıles				
	(1) R (Retirement Plan Information)	(1)	X		Н	(Fina	ancial I	nforma	tion)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	Ц		ı	(Fina	ancial I	nforma	tion - Sı	mall Plan)
	Purchase Plan Actuarial Information) - signed by the plan	(3)	X		Α	•			•	Number Attached <u>4</u>
	actuary	(4)	X		С	•			Informa	•
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	Н		D					nformation)
	Information) - signed by the plan actuary	(6)	Ц	l	G	(Fina	ancial [*]	ıransac	tion Sc	hedules)
	(4) DCG (Individual Plan Information) - Number Attached (5) MEP (Multiple-Employer Retirement Plan Information)									
	(U) INTER (INICIDITE EMPLOYED RECIDENTE FIGURITION AND MICHAELOTT)									

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

► File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2023

This Form is Open to

Pension Benefit Guar	pursuant to ERISA section 103(a)(2).						" 1	Public Inspection		
For calendar plan year 20	023 or fiscal plar	n year beginning 01/01	L/202	3	and ending	g	12/31/20	23		
A Name of plan MASSACHUSET	TS BANK	ERS ASSOCIATION					ree-digit an number (PN)		501	
<u>MASSACHUSET</u>	TS BANK	on line 2a of Form 5500 ERS ASSOCIATION cerning Insurance Con			s and C		nployer Identifica 04-1589	780		
		e Schedule A. Individual contr								
1 Coverage Informa	ation:		-							
(a) Name of insuranc	e carrier									
BLUE CROSS	BLUE SH	IELD OF MA-DENT	AL							
(b) EIN	(c) NAIC code	(d) Contract or identification number		Approximate nun ed at end of polic				or cont	ract year	
	3343	Tuestanious training of	1 30.00		,	,	(f) From	+	(g) To	
04-1045815	53228	MULTIPLE			8	731	01/01/20	231	2/31/2023	
2 Insurance fee and in descending ord		nformation. Enter the total fee unt paid.	s and tot	al commissions p	aid. List in I	ine 3 the	e agents, brokers	s, and o	other persons	
(a)	Total amount	of commissions paid			(b) T	otal am	ount of fees paid	L L		
3 Persons receiving			0		. . II	-1			0	
Persons receiving		and fees. (Complete as many and address of the agent, brok					fees were naid			
(b) Amount of sal	es and base		Fees	s and other comm	issions paid	d			(e)	
commission	ns paid	(c) Amount			(d) Purp	ose			Organization code	
					(-7 1					
	(a) Nama	and address of the agent, brok	or or oth	hor norson to who	am commiss	sions or	foos woro poid			
	(a) Name a	and address of the agent, blor	oi, oi oti	noi person to will	in commiss	ions ul	ices were paid			
(b) Amount of sal			Fees	s and other comm					(e) Organization	
	•	(c) Amount			(d) Purp	ose			code	
For Danorwork Dodu	etion Act Not	ica soo the Instructions for	Form 55	00			Cohod	ulo A /	Form FE00\ 2022	

Schedule A (Form 5500) 202 v. 230728

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

_					
P	art	•			
		Where individual contracts are provided, the entire group of such purposes of this report.	n individual contracts with each c	arrier ma	ay be treated as a unit for
4	Curr	rent value of plan's interest under this contract in the general account at	year end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at y	ear end	5	
6	Con	tracts With Allocated Funds:			
8	3 St	ate the basis of premium rates			
k) Pr	emiums paid to carrier		6b	
		emiums due but unpaid at the end of the year		6c	
C		the carrier, service, or other organization incurred any specific costs in c			
	th	e acquisition or retention of the contract or policy, enter amount		6d	
		pecify nature of costs			
E	> Ty	pe of contract: (1) 📙 individual policies (2) 📙 group deferre	d annuity		
	(3)	other (specify)			
_†		contract purchased, in whole or in part, to distribute benefits from a terr)	
7		ontracts With Unallocated Funds (Do not include portions of these contr	· ·		
a	Ту	rpe of contract: (1) deposit administration (2)	immediate participation guaran	tee	
		(3) guaranteed investment (4)	other >		
				71-	
		alance at the end of the previous year	[7-4)	7b	
C	Ac	dditions: (1) Contributions deposited during the year	7c(1)		
	(2)	Dividends and credits	7c(2)		
	(3)	Interest credited during the year	7c(3)		
	(4)		7c(4)		
	(5)	Other (specify below)	7c(5)		
				7 (0)	
		Total additions		7c(6)	0
		otal of balance and additions (add lines 7b and 7c(6))		7d	
e		eductions:	7.4		
		Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2)	Administration charge made by carrier	7e(2)		
	(3)	Transferred to separate account	7e(3)		
	(4)	Other (specify below)	7e(4)		
				7-/5	^
,		Total deductions		7e(5)	0
T	D.	planes at the and of the current year (cultivat line 7a/E) from line 7d		7 f	İ

	Welfare Benefit Contract Information If more than one contract covers the same group of employee organization(s), the information may be combine as a unit. Where contracts cover individual employees, the treated as a unit for purposes of this report.	ed for reportin	g purposes if such	contracts are	experience-rated
8	Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) b X Dental e Temporary disability (accident and sickness) f Long-term Stop loss (large deductible) j HMO cont m Other (specify)	-	c Vision g Supplement k PPO contrac		nent d Life insurance Prescription drug Indemnity contract
9	Experience-rated contracts:				
а	Premiums: (1) Amount received	9a(1)	9.40	9,092	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	<i>- , - ,</i>	7,00	
	(3) Increase (decrease) in unearned premium reserve	9a(3)			
				9a(4)	9,409,092
h	(4) Earned ((1) + (2) - (3))	9b(1)		9,934	J, 40J, 0JZ
D	Benefit charges (1) Claims paid		0,24	9,934	
	(2) Increase (decrease) in claim reserves			01- (0)	0 040 034
	(3) Incurred claims (add (1) and (2))			9b(3)	8,249,934
	(4) Claims charged			9b(4)	8,364,875
С	Remainder of premium: (1) Retention charges (on an accrual basis)	[]			
	(A) Commissions	9c(1)(A)			
	(B) Administrative service or other fees	9c(1)(B)			
	(C) Other specific acquisition costs	9c(1)(C)			
	(D) Other expenses	9c(1)(D)			
	(E) Taxes	9c(1)(E)	11	1,027	
	(F) Charges for risks or other contingencies	9c(1)(F)		-	
	(G) Other retention charges	9c(1)(G)	93	3,189	
	(H) Total retention			9c(1)(H)	1,044,216
	(2) Dividends or retroactive rate refunds. (These amounts were			9c(2)	, , , , , , , , , , , , , , , , , , , ,
d	Status of policyholder reserves at end of year: (1) Amount held to pro-			9d(1)	
	(2) Claim reserves			9d(2)	
				9d(3)	
_	(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount ent			9e	
10	·	ered iii iiile s	C(2).)	1 00	
	Nonexperience-rated contracts:			10a	
a h	p p 9 p			100	
IJ	If the carrier, service, or other organization incurred any specific costs				
	the acquisition or retention of the contract or policy, other than report	ted in Part I, li	ne 2	406	
	above, report amount			10b	
S	pecify nature of costs.				

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

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2023

Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).						Pi	This Form is Open to Public Inspection		
For calendar plan year 20	023 or fiscal plan	year beginning 01/01	L/202	3 and ending	g	12/31/202	3		
A Name of plan MASSACHUSET	TS BANK	ERS ASSOCIATION			1	ree-digit an number (PN)	501		
MASSACHUSET	TS BANK	on line 2a of Form 5500 ERS ASSOCIATION				nployer Identificatio	80		
	t on a separate	cerning Insurance Con Schedule A. Individual contra		= '				ach	
(a) Name of insurance									
. ,		IELD OF MA - ME	DEX						
(In) FINI	(c) NAIC	(d) Contract or	(e)	Approximate number of pers	ons	Policy or	contract year	ntract year	
(b) EIN	code	identification number		ed at end of policy or contrac		(f) From	(g) To		
04-1045815		MULTIPLE			645	01/01/202			
Insurance fee and in descending ord		formation. Enter the total fee: nt paid.	s and tota	al commissions paid. List in l	ine 3 the	e agents, brokers, a	and other person	s 	
(a)	Total amount of	f commissions paid		(b) [↑]	otal am	ount of fees paid			
3 Persons receiving	commissions	and fees. (Complete as many	0 entries as	s needed to report all person	s).			0	
	(a) Name a	nd address of the agent, brok	ker, or oth	er person to whom commiss	sions or	fees were paid			
(b) Amount of sal	es and base		Fees and other commissions paid				(e) Organiza	tion	
commissior	ns paid	(c) Amount		(d) Purp	ose		code		
	(a) Nama a	nd address of the agent, brok	or or oth	or pareen to whom commiss	iono or	foce were poid			
	(a) Name a	nd address of the agent, brok	ter, or our	er person to whom commiss	510113-01	iees were paid			
(b) Amount of sal			Fees	and other commissions paid	d		(e) Organiza		
commissior	is paid	(c) Amount		(d) Purp	ose		code		
For Paperwork Redu	ction Act Noti	ce. see the Instructions for I	Form 550	00.		Schedule	A (Form 5500)	2023	

v. 230728

Fees and other commissions paid

(d) Purpose

(b) Amount of sales and base

commissions paid

(c) Amount

(e)

Organization

code

_					
P	art	•			
		Where individual contracts are provided, the entire group of such purposes of this report.	n individual contracts with each c	arrier ma	ay be treated as a unit for
4	Curr	rent value of plan's interest under this contract in the general account at	year end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at y	rear end	5	
6	Con	tracts With Allocated Funds:			
8	3 St	ate the basis of premium rates			
k) Pr	emiums paid to carrier		6b	
		emiums due but unpaid at the end of the year		6c	
C		the carrier, service, or other organization incurred any specific costs in c			
	th	e acquisition or retention of the contract or policy, enter amount		6d	
		pecify nature of costs			
E	> Ty	pe of contract: (1) 📙 individual policies (2) 📙 group deferre	d annuity		
	(3)	other (specify)			
_†		contract purchased, in whole or in part, to distribute benefits from a terr)	
7		ontracts With Unallocated Funds (Do not include portions of these contr	· ·		
a	Ту	rpe of contract: (1) deposit administration (2)	immediate participation guaran	tee	
		(3) guaranteed investment (4)	other >		
				71-	
		alance at the end of the previous year	[7-4)	7b	
C	Ac	dditions: (1) Contributions deposited during the year	7c(1)		
	(2)	Dividends and credits	7c(2)		
	(3)	Interest credited during the year	7c(3)		
	(4)		7c(4)		
	(5)	Other (specify below)	7c(5)		
				7 (0)	
		Total additions		7c(6)	0
		otal of balance and additions (add lines 7b and 7c(6))		7d	
e		eductions:	7.4		
		Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2)	Administration charge made by carrier	7e(2)		
	(3)	Transferred to separate account	7e(3)		
	(4)	Other (specify below)	7e(4)		
				7-/5	^
,		Total deductions		7e(5)	0
T	D.	planes at the and of the current year (cultivat line 7a/E) from line 7d		7 f	İ

_					
Pa	Welfare Benefit Contract Information If more than one contract covers the same group of employee organization(s), the information may be combine	•			
	as a unit. Where contracts cover individual employees, the treated as a unit for purposes of this report.	•	•		•
8	Benefit and contract type (check all applicable boxes)				
	a X Health (other than dental or vision) b Dental		c Vision		d Life insurance
	e Temporary disability (accident and sickness) f Long-term	disability	g Supplementa	al unemployn	nent h Prescription drug
	i Stop loss (large deductible) j HMO cont		k ☐ PPO contrac		Indemnity contract
	m X Other (specify) ► MEDICARE SUPPLEMENTAL	GROUP 1	MEDICAL		_ ′
9	Experience-rated contracts:				
а	Premiums: (1) Amount received	9a(1)	1,43	0,667	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	-	-	
	(3) Increase (decrease) in unearned premium reserve	9a(3)			
	(4) Earned ((1) + (2) - (3))			9a(4)	1,430,667
b	Benefit charges (1) Claims paid	9b(1)	1,31	1,182	-
	(2) Increase (decrease) in claim reserves	9b(2)	-	-	
	(3) Incurred claims (add (1) and (2))			9b(3)	1,311,182
	(4) Claims charged			9b(4)	1,322,983
С	Remainder of premium: (1) Retention charges (on an accrual basis)				-
	(A) Commissions	9c(1)(A)			
	(B) Administrative service or other fees	9c(1)(B)			
	(C) Other specific acquisition costs	9c(1)(C)			
	(D) Other expenses	9c(1)(D)			
	(E) Taxes	9c(1)(E)			
	(F) Charges for risks or other contingencies	9c(1)(F)			
	(G) Other retention charges	9c(1)(G)	10	7,684	
	(H) Total retention			9c(1)(H)	107,684
	(2) Dividends or retroactive rate refunds. (These amounts were	paid in cash,	or credited.)	9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to pro-	vide benefits	after retirement	9d(1)	
	(2) Claim reserves			9d(2)	
	(3) Other reserves			9d(3)	
е				9e	
10	Nonexperience-rated contracts:				
а	Total premiums or subscription charges paid to carrier			10a	
b	If the carrier, service, or other organization incurred any specific costs				
	the acquisition or retention of the contract or policy, other than report				
	above, report amount			10b	
S	pecify nature of costs.				

Pa	art IV Provision of Information				
<u>11</u>	Did the insurance company fail to provide any information necessary to complete Schedule A?	\prod	Yes	X	No
12	If the answer to line 11 is "Yes," specify the information not provided.				

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

➤ File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2023

This Form is Open to

pursuant to ERISA section 103(a)(2).						Public Inspection		
or calendar plan year 2023 or fiscal plan ye	ear beginning 01/01	/202	3 and endir	ıg	12/31/	2023		
A _{Name of plan} IASSACHUSETTS BANKEI	RS ASSOCIATION			1	ree-digit an number (F	PN) 	501	
Plan sponsor's name as shown on MASSACHUSETTS BANKER	line 2a of Form 5500	TNC	,	D En	nployer Ident		Number (EIN)	
Part I Information Conce	erning Insurance Cont Schedule A. Individual contra	ract C	overage, Fees, and C		ssions Pr	ovide info	ormation for each	
Coverage Information:								
a) Name of insurance carrier								
BLUE CROSS/BLUE SHI	ELD-MEDICAL							
(b) EIN (c) NAIC	(d) Contract or		Approximate number of per		Po	licy or co	ntract year	
code	identification number	covered at end of policy or contract ye			(f) Fro	om	(g) To	
	ULTIPLE					•	12/31/202	
Insurance fee and commission info in descending order of the amount		and tota	al commissions paid. List in	line 3 the	e agents, bro	okers, and	d other persons	
(a) Total amount of o	commissions paid		(b)	Total am	ount of fees	paid		
<u> </u>		0					0	
Persons receiving commissions an	d fees. (Complete as many ed address of the agent, broke				foos woro no	nid.		
(b) Amount of sales and base		Fees	and other commissions pai	d			(e)	
commissions paid	(c) Amount						Organization code	
	(c) / unounc		(d) i dip	,000				
(a) Name and	d address of the agent, broke	er, or oth	er person to whom commis	sions or	fees were pa	aid		
(b) Amount of sales and base		Foos	and other commissions pai	d			(e)	
commissions paid	(c) Amount	i-ees	(d) Purp				Organization code	
or Paperwork Reduction Act Notice							(Form 5500) 202	

v. 230728

Schedule A (Form 5500) 2023		Page 2-		
(a) Name and	d address of the agent, bro	ker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and	d address of the agent, bro	ker, or other person to whom commissions or fees were paid		
(a) Name and	u address of the agent, bro	ker, or other person to whom commissions or lees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and	d address of the agent, bro	ker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization code	
commissions paid	(c) Amount	(d) Purpose		
(a) Name and	d address of the agent. bro	ker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
	(c) Amount	(d) Purpose	code	
(a) Name and	d address of the agent, bro	ker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

(c) Amount

(d) Purpose

_					
P	art	•			
		Where individual contracts are provided, the entire group of such purposes of this report.	n individual contracts with each c	arrier ma	ay be treated as a unit for
4	Curr	rent value of plan's interest under this contract in the general account at	year end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at y	rear end	5	
6	Con	tracts With Allocated Funds:			
8	3 St	ate the basis of premium rates			
k) Pr	emiums paid to carrier		6b	
		emiums due but unpaid at the end of the year		6c	
C		the carrier, service, or other organization incurred any specific costs in c			
	th	e acquisition or retention of the contract or policy, enter amount		6d	
		pecify nature of costs			
E	> Ty	pe of contract: (1) 📙 individual policies (2) 📙 group deferre	d annuity		
	(3)	other (specify)			
_†		contract purchased, in whole or in part, to distribute benefits from a terr)	
7		ontracts With Unallocated Funds (Do not include portions of these contr	· ·		
a	Ту	rpe of contract: (1) deposit administration (2)	immediate participation guaran	tee	
		(3) guaranteed investment (4)	other >		
				71-	
		alance at the end of the previous year	[7-4)	7b	
C	Ac	dditions: (1) Contributions deposited during the year	7c(1)		
	(2)	Dividends and credits	7c(2)		
	(3)	Interest credited during the year	7c(3)		
	(4)		7c(4)		
	(5)	Other (specify below)	7c(5)		
				7 (0)	
		Total additions		7c(6)	0
		otal of balance and additions (add lines 7b and 7c(6))		7d	
e		eductions:	7.4		
		Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2)	Administration charge made by carrier	7e(2)		
	(3)	Transferred to separate account	7e(3)		
	(4)	Other (specify below)	7e(4)		
				7-/5	^
,		Total deductions		7e(5)	0
T	D.	planes at the and of the current year (cultivat line 7a/E) from line 7d		7 f	İ

_					
Pa	Welfare Benefit Contract Information If more than one contract covers the same group of employee organization(s), the information may be combined as a unit Where contracts accordingly individual amployees the	ed for reportin	g purposes if such	contracts are	experience-rated
	as a unit. Where contracts cover individual employees, the treated as a unit for purposes of this report.	e entire group	of such individual c	ontracts with	i each carrier may be
8	Benefit and contract type (check all applicable boxes) a X Health (other than dental or vision) b Dental e Temporary disability (accident and sickness) f Long-term		C Vision Supplementa		
	i Stop loss (large deductible) M Other (specify) ▶ J ☑ HMO conf	tract	k X PPO contrac	t	I 🛚 Indemnity contract
9	Experience-rated contracts:				
а	Premiums: (1) Amount received	9a(1)	172,75	5,342	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	•	·	
	(3) Increase (decrease) in unearned premium reserve	2 (2)			
	(4) Earned ((1) + (2) · (3))			9a(4)	172,755,342
b	Benefit charges (1) Claims paid	9b(1)	166,33		1,27,00,012
	(2) Increase (decrease) in claim reserves		200,00	<u> </u>	
	(3) Incurred claims (add (1) and (2))			9b(3)	166,333,147
	(4) Claims charged			9b(4)	167,856,796
c	Remainder of premium: (1) Retention charges (on an accrual basis)				10,,030,,30
		9c(1)(A)			
	(A) Commissions	9c(1)(B)			
	(B) Administrative service or other fees	9c(1)(C)			
	(C) Other specific acquisition costs	9c(1)(D)			
	(D) Other expenses	9c(1)(E)	72	4,350	
	(E) Taxes	0 - (4) (5)	73	4,330	
	(F) Charges for risks or other contingencies	0-(4)(0)	1 1 C	1 100	
	(G) Other retention charges			4,196	4 000 546
	(H) Total retention			9c(1)(H)	4,898,546
	(2) Dividends or retroactive rate refunds. (These amounts were	•		9c(2)	
a	Status of policyholder reserves at end of year: (1) Amount held to pro	vide benefits	after retirement	9d(1)	
	(2) Claim reserves			9d(2)	
	(3) Other reserves			9d(3)	
_e	Dividends or retroactive rate refunds due. (Do not include amount en	tered in line	Oc(2).)	9e	
10	Nonexperience-rated contracts:				
а	Total premiums or subscription charges paid to carrier			10a	
b	If the carrier, service, or other organization incurred any specific cost	s in connectio	n with		
	the acquisition or retention of the contract or policy, other than repor	ted in Part I, I	ine 2		
	above, report amount			10b	
S	pecify nature of costs.				

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

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

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

File as an attachment to Form 5500.

Insurance Information

OMB No. 1210-0110

2023

Pension Benefit Guaranty Corporation Insurance companies are required to provide the info pursuant to ERISA section 103(a)(2).					ormatio	n	This Form is Open to Public Inspection			
For calendar plan year 202	23 or fiscal plan y	vear beginning 01/01	/202	3	and ending	l	12/31	/2023		
A Name of plan						B Thr	ee-digit			
	rs banke	RS ASSOCIATION				pla	n number	(PN)	501	
		n line 2a of Form 5500 RS ASSOCIATION	. INC			D Em		ntification	Number (EIN)	
Part I Inform	ation Conc on a separate	erning Insurance Cont Schedule A. Individual contra	ract C	overage, Fee			sions F	Provide inf	ormation for eac	h
Coverage Information	IOTI.									
(a) Name of insurance	carrier									
NATIONAL UN	ION FIRE	INS. CO. OF PI	ITTSI	BURGH						
(b) EIN	(c) NAIC	(d) Contract or	(e)	Approximate nur	nber of pers	ons	Р	Policy or contract year		
(b) EIN	code	identification number	covered at end of policy or contract		t year	year (f) F	rom	(g) To		
25-0687550	19445	TP 0009101853A			7:	378	01/01	/2023	12/31/20	23
2 Insurance fee and on in descending order		ormation. Enter the total fees t paid.	and tota	al commissions p	aid. List in li	ne 3 the	agents, b	rokers, and	d other persons	
(a) T	otal amount of	commissions paid			(b) ⊤	otal amo	ount of fee	s paid		
			922							0
3 Persons receiving		nd fees. (Complete as many e								
MASS FINANCI	IAL SERV	Id address of the agent, broke ICES INS. AGENO 8TH FLOOR		ner person to who	om commiss	ions or f	ees were p	oaid		
BOSTON		· =	8-26	18						
(b) Amount of sale			Fees	and other comm	nissions paid				(e) Organizat	ion
commissions	s paid	(c) Amount			(d) Purpo	se			code	
	2,922								3	
	(a) Name ar	d address of the agent, broke	er, or oth	ner person to who	om commiss	ions or f	ees were p	paid		
(b) Amount of sale	es and base		Fees	and other comm	nissions paid				(e)	
commissions	s paid	(c) Amount			(d) Purpo	•			Organization code	
		(c) / anount			(u) i dipo					
		a see the Instructions for F					_		(Form 5500) 2	

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

Schedule A (Form 5500) 202 v. 230728

Fees and other commissions paid

(d) Purpose

(b) Amount of sales and base

commissions paid

(c) Amount

(e)

Organization

code

Par	rt II Investment	and Annuity Contract Information			
	Where individu purposes of th	al contracts are provided, the entire group of sucis report.	ch individual contracts with each c	arrier may b	e treated as a unit for
1 Cι	urrent value of plan's int	erest under this contract in the general account a	at year end	4	
5 Cι	urrent value of plan's int	erest under this contract in separate accounts at	year end	5	
6 Co	ontracts With Allocated	Funds:			
а	State the basis of prem	ium rates 🕨			
b	Premiums paid to carrie	er		6b	
С	Premiums due but unpa	aid at the end of the year		6c	
d	If the carrier, service, or	other organization incurred any specific costs in	connection with		
	the acquisition or retent	ion of the contract or policy, enter amount		6d	
	Specify nature of costs	7			
е	Type of contract: (1)	- · · · - · · ·	ed annuity		
	(3) U other (specify)	>			
				. \Box	
_		n whole or in part, to distribute benefits from a te		▶∐	
		ated Funds (Do not include portions of these con	→	· ·	
а	Type of contract: (1)	deposit administration (2)	immediate participation guaran	tee	
	(3)	guaranteed investment (4)	other -		
h	Dalamas at the anal of th			7b	
		ne previous year	7c(1)	175	
	(2) Dividends and cred		7c(2)		
	()	ring the year	7c(3)		
		parate account	7c(4)		
	(5) Other (specify below		7c(5)		
	Other (speedify below				
	(6) Total additions			7c(6)	0
		ditions (add lines 7b and 7c(6))		7d	
е	Deductions:				
	(1) Disbursed from fund t	o pay benefits or purchase annuities during year	7e(1)		
	(2) Administration char	ge made by carrier	7e(2)		
	(3) Transferred to sepa	rate account	7e(3)		
	(4) Other (specify below	v)	7e(4)		
	>				
				_ (=)	
				7e(5)	0
+	Deleges at the seed of the	a aureant year (aubtract line 7a/E) from line 7d)		7f	

Pa	art III	Welfare Benefit Contract Information				
		If more than one contract covers the same group of emplo	oyees of the	same employer(s) or	members of th	ne same
employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated						
		as a unit. Where contracts cover individual employees, the	e entire group	o of such individual	contracts with	each carrier may be
		treated as a unit for purposes of this report.				
8	Benefit	and contract type (check all applicable boxes)				
		Health (other than dental or vision)		c Vision		d Life insurance
		emporary disability (accident and sickness)	disability	H ' '	al unemployme	. H
	. \square	Stop loss (large deductible)	-	k PPO contrac		I Indemnity contract
		Other (specify) ACCIDENTAL DEATH & DIS				
9		ence-rated contracts:		-		
а	•	ms: (1) Amount received	9a(1)			
		crease (decrease) in amount due but unpaid	0 (0)			
		crease (decrease) in unearned premium reserve	2 (2)			
		arned ((1) + (2) - (3))		1	9a(4)	
b		charges (1) Claims paid	01 (4)		1 2 2 (2 /	
		crease (decrease) in claim reserves				
		curred claims (add (1) and (2))		1	9b(3)	
		laims charged			9b(4)	
С		nder of premium: (1) Retention charges (on an accrual basis)				
_		Commissions	9c(1)(A)			
		Administrative service or other fees	9c(1)(B)			
	(C		9c(1)(C)			
	(C		9c(1)(D)			
	(E		9c(1)(E)			
	(E		0 (4)(F)			
	(i (G		2 (1)(2)			
	(E				9c(1)(H)	
	,	ividends or retroactive rate refunds. (These amounts were			9c(2)	
d		of policyholder reserves at end of year: (1) Amount held to pro			9d(1)	
_		laim reserves			9d(2)	
					9d(3)	
е		ther reserves nds or retroactive rate refunds due. (Do not include amount en			9e	
10		perience-rated contracts:	tered in line	90(2).)	1 33	
a		remiums or subscription charges paid to carrier			10a	19,478
b		arrier, service, or other organization incurred any specific cost				17,470
_		quisition or retention of the contract or policy, other than repor				
		report amount			10b	
9		ature of costs.				
J	Decity 116	ature of costs.				
P	art IV	Provision of Information				
11		e insurance company fail to provide any information necessary	to complete	Schedule A2	П	Yes X No
12		nswer to line 11 is "Yes," specify the information not provided		Concado A!		100 [2] 110
_	a					

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

2023

OMB No. 1210-0110

► File as an attachment to Form 5500.

This Form is Open to Public Inspection.

Pension Benefit Guaranty Corporation	► File as an att	achment to Form 5500.		Public Ir	spection.
For calendar plan year 2023 or fiscal pl	an year beginning 01/01/2	2023 and endin	g 12/	31/2023	
A Name of plan MASSACHUSETTS BANKER	RS ASSOCIATION		B Three-o	digit umber (PN) >	501
C Plan sponsor's name as shown on MASSACHUSETTS BANKER				yer Identificatio	on Number (EIN)
Part I Service Provider Info	rmation (see instructions)				
You must complete this Part, in accindirectly, \$5,000 or more in total cothe person's position with the plan of	ordance with the instructions, to repo ompensation (i.e., money or anything of during the plan year. If a person received to answer line 1 but are not require	else of monetary value) in connect red only eligible indirect compen	ion with ser sation for wh	vices rendered nich the plan re	to the plan or eceived the
1 Information on Persons Re	ceiving Only Eligible Indirect	Compensation			
a Check "Yes" or "No" to indicate who		the remainder of this Part becau	•	•	Yes X No
b If you answered line 1a "Yes," enter who received only eligible indirect co	the name and EIN or address of each ompensation. Complete as many entr		sclosures fo	r the service pr	oviders
(b) Enter name ar	nd EIN or address of person who prov	ided you disclosures on eligible in	direct comp	ensation	
(In) Fatou name on	od CINI au adducac af managa uda angu		-l:		
(b) Linter Harrie ai	nd EIN or address of person who prov	idea you disclosures on eligible ill	direct comp	ensauon	
(h) Enter name an	nd EIN or address of person who prov	ided you disclosures on eligible in	direct comp	ensation	
(b) Ento Tumo a	a Environ addition of policen who prov	naca you alcolocal to cit oligizio	ian eet eemp	onouner:	
(b) Enter name ar	d EIN or address of person who prov	ided you disclosures on eligible in	direct comp	ensation	
For Paperwork Reduction Act Notice	see the instructions for Form 5500	J.	<u> </u>	schedule C (Fo	orm 5500) 2023

318451 11-21-23

v. 230728

Schedule C (Form 5500) 2023	Page 2 -
(b) Enter name and EIN or address of person who provided	you disclosures on cligible indirect compensation
(b) Enter hame and Envior address of person who provided	you disclosures on engine mairect compensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation

	2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom							
•		. •		·	rson receiving, directly or indire	• • •		
	al compensation (i.e., m an year. (See instructio		g else of value) in conne	ction with services rende	red to the plan or their position	with the plan during		
- пс рі	arr year. (Oce matruette	, iii	(3) ====================================	l	:\			
MASS	FIN SERVICE	S TNS ACT		or address (see instruct 04-2680895	ions)			
	ASHINGTON M			04 2000055				
BOSTO		MA						
DODIO	-1		02100					
(b)	(c)	(d)	(e)	(f)	(g)	(h)		
Service	Relationship to	Enter direct	Did service provider	Did indirect	Enter total indirect	Did the service		
Code(s)	employer, employee organization, or	compensation paid by the	receive indirect compensation?	compensation include eligible indirect	compensation received by service provider excluding	provider give you a formula instead		
	person known to be	plan. If none,	(sources other	compensation, for	eligible indirect	of an amount or		
	a party-in-interest	enter -0	than plan or	which the plan received the	compensation for which you answered "Yes" to element	estimated amount?		
			plan sponsor)	required disclosures?	(f). If none, enter -0			
12	NONE							
13 2,922. Yes X No Yes X No 523					523,393.	Yes No X		
			(a) Enter name and EIN	or address (see instruct	ions)			
	& DOWNEY		4	52-1839270				
	OWSONTOWN B	-	ITE 1 EAST					
BALTI	MORE	MD	21286					
		/ n		10		<i>n</i> >		
(b)	(c)	(d)	(e)	(f) Did indirect	(g) Enter total indirect	(h)		
Service Code(s)	Relationship to employer, employee	Enter direct compensation	Did service provider receive indirect	compensation include	compensation received by	Did the service provider give you		
0000(0)	organization, or	paid by the	compensation?	eligible indirect	service provider excluding	a formula instead		
	person known to be	plan. If none,	(sources other	compensation, for which the plan	eligible indirect compensation for which you	of an amount or		
	a party-in-interest	enter -0	than plan or plan sponsor)	received the	answered "Yes" to element	estimated amount?		
	11011		pian spenden)	required disclosures?	(f). If none, enter -0			
29	NONE	67 573		l		🗆 🗆		
		67,573.	Yes No 🛚	Yes No		Yes No		
			(a) Enter name and EIA	Lar address (see instruct	iana)			
WOLE	& COMPANY,	P C	(a) Enter hame and En	or address (see instruct	lons)			
	TATE STREET			04 2007003				
BOSTO		MA	02109					
DODIO	-1	1111	02105					
(b)	(c)	(d)	(e)	(f)	(g)	(h)		
Service	Relationship to	Enter direct	Did service provider	Did indirect	Enter total indirect	Did the service		
Code(s)	employer, employee	compensation	receive indirect	compensation include	compensation received by	provider give you		
	organization, or person known to be	paid by the plan. If none,	compensation? (sources other	eligible indirect compensation, for	service provider excluding eligible indirect	a formula instead of an amount or		
	a party-in-interest	enter -0	than plan or	which the plan	compensation for which you	estimated amount?		
			plan sponsor)	received the required disclosures?	answered "Yes" to element (f). If none, enter -0			
10	NONE			required disclosures?	(i). Il Hone, enter o.			
- 0		19,350.	Yes No X	Yes No		Yes No		
		== , == •	103 🔲 140 🖼	103 140		163 🖺 140 🖺		

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	l or address (see instruct	ions)			
1101	IBERTE GROUP LLC 26-2435423 101 PENNSYLVANIA AVE NW, SUITE 600 ASHINGTON DC 20004							
(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?	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	NONE	16,256.	Yes No 🛚	Yes No		Yes No		
			(a) Enter name and EIN	l or address (see instruct	ions)			
		(1)		(0)				
(b) Service Code(s)	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?	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 No	Yes No		Yes No		
			(a) Enter name and EIN	l or address (see instruct	ions)			
(b) Service Code(s)	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?	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 No	Yes No		Yes No		

Part I Service Provider Information (continued)

3.	If you reported on line 2 receipt of indirect compensation, other than eligible indirect compe	nsation, by a service provide	er, and the service provider
	is a fiduciary or provides contract administrator, consulting, custodial, investment advisory,	investment management, br	oker, or recordkeeping
	services, answer the following questions for (a) each source from whom the service provide		
	(b) each source for whom the service provider gave you a formula used to determine the inc		
	amount of the indirect compensation. Complete as many entries as needed to report the rec	quired information for each s	source.

amount of the indirect compensation. Complete as many entries as needed to report the	e required information for each	source.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	l eligibility for or t	I t compensation, including mine the service provider's the amount of the mpensation.
	<u> </u>	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	eligibility for or t	t compensation, including mine the service provider's the amount of the mpensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect any formula used to deter eligibility for or to indirect co	t compensation, including mine the service provider's the amount of the mpensation.

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).

2023

OMB No. 1210-0110

► File as an attachment to Form 5500.

This Form is Open to Public Inspection

F	or calendar plan year 2023 or fiscal plan year beginning 01/01/2023	ar	nd endin	g 12/31	/20	23
A N	ame of plan		E	3 Three-digit		
				plan number (F	N) 🕨	501
MAS	SSACHUSETTS BANKERS ASSOCIATION					
C PI	an sponsor's name as shown on line 2a of Form 5500		[Employer Ident	ificatio	on Number (EIN)
	SSACHUSETTS BANKERS ASSOCIATION, INC.			04-1589	780	
Pa	TI Asset and Liability Statement					
1	Current value of plan assets and liabilities at the beginning and end of the plan year					
	trust. Report the value of the plan's interest in a commingled fund containing the as value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that porti					
	plan year, to pay a specific dollar benefit at a future date. Round off amounts to the	he nearest	t dollar.	MTIAs, CCTs, PS	As, an	d 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 con	nplete lir	nes 1d and 1e. See	e instru	ictions.
	Assets		(a) B	eginning of Year	(1	b) End of Year
а	Total noninterest-bearing cash	1a				
b	Receivables (less allowance for doubtful accounts):					
	(1) Employer contributions	1b(1)				
	(2) Participant contributions	1b(2)				
	(3) Other SEE STATEMENT 1	1b(3)		300,818		305,743
С	General investments:					
	(1) Interest-bearing cash (incl. money market accounts & certificates of deposit)	1c(1)		<u>4,735,683</u>		4,748,808
	(2) U.S. Government securities	1c(2)				
	(3) Corporate debt instruments (other than employer securities):					
	(A) Preferred	1c(3)(A)				
	(B) All other	1c(3)(B)				
	(4) Corporate stocks (other than employer securities):					
	(A) Preferred	1c(4)(A)				
	(B) Common	1c(4)(B)				
	(5) Partnership/joint venture interests	1c(5)				
	(6) Real estate (other than employer real property)	1c(6)				
	(7) Loans (other than to participants)	1c(7)				
	(8) Participant loans	1c(8)				
	(9) Value of interest in common/collective trusts	1c(9)				
(10) Value of interest in pooled separate accounts	1c(10)				
(11) Value of interest in master trust investment accounts	1c(11)				
(12) Value of interest in 103-12 investment entities	1c(12)				
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)				
(14) Value of funds held in insurance co. general account (unallocated contracts)	1c(14)				
(15) Other	1c(15)				

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

Schedule H (Form 5500) 2023 v. 230728

318501 11-21-23

1 d	Employer related investments:	Г	(a) Beginning of Year	(b) End of Year
·u	Employer-related investments:	\vdash	(a) Degitting of Teal	(b) End of Teal
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
е	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	5,036,501	5,054,551
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h	22,917	56,180
i	Acquisition indebtedness	1i		
j	Other liabilities SEE STATEMENT 2	1j		15,700
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	22,917	71,880
	Net Assets			
I	Net assets (subtract line 1k from line 1f)	11	5,013,584	4,982,671

Part II Income and Expense Statement

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

	Income		(a) Amount	(b) Total
а	Contributions:			
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	20,704	
	(B) Participants	2a(1)(B)		
	(C) Others (including rollovers)	2a(1)(C)		
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		20,704
b	Earnings on investments:			
	(1) Interest:			1
	(A) Interest-bearing cash (including money market			
	accounts and certificates of deposit)	2b(1)(A)	70,266	
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		_
	(E) Participant loans	2b(1)(E)		_
	(F) Other	2b(1)(F)		
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		70,266
	(2) Dividends: (A) Preferred stock	2b(2)(A)		_
	(B) Common stock	2b(2)(B)		_
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		-
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		-
	(B) Other	2b(5)(B)		
	(C) Total unrealized appreciation of assets.			
	Add lines 2b(5)(A) and (B)	2b(5)(C)		<u> </u>

			(a) Amount	(b) Total
	(6) Net investment gain (loss) from common/collective trusts	2b(6)	` '	
	(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
	(8) Net investment gain (loss) from master trust investment accounts			
	(9) Net investment gain (loss) from 103-12 investment entities	01 (0)		
	(10) Net investment gain (loss) from registered investment companies			
	(e.g., mutual funds)	2b(10)		
C	Other income SEE STATEMENT 3	. 2c		78,646
d	Total income. Add all income amounts in column (b) and enter total Expenses	2d		169,616
е	Benefit payment and payments to provide benefits:			
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		
	(2) To insurance carriers for the provision of benefits	2e(2)	19,478	
	(3) Other	2e(3)		
	(4) Total benefit payments. Add lines 2e(1) through (3)			19,478
f	Corrective distributions (see instructions)	. 2f		
g	Certain deemed distributions of participant loans (see instructions)	2g	_	
h	Interest expense	. 2h	_	
i	Administrative expenses:			
	(1) Salaries and allowances	2i(1)		
	(2) Contract administrator fees	2i(2)	1,226	
	(3) Record keeping fees	. 2i(3)		
	(4) IQPA audit fees			
	(5) Investment advisory and investment management fees			
	(6) Bank or trust company trustee/custodial fees			
	(7) Actuarial fees			
	(8) Legal fees		83,829	
	(9) Valuation/appraisal fees			
	(10) Other trustee fees and expenses	2i(10)	25.006	
	(11) Other expenses SEE STATEMENT 4		95,996	101 051
	(12) Total administrative expenses. Add lines 2i(1) through (11)		-	181,051
J	Total expenses. Add all expense amounts in column (b) and enter total Net Income and Reconciliation	2 j		200,529
k	Net income (loss). Subtract line 2j from line 2d	. 2k		-30,913
ı	Transfers of assets:			
	(1) To this plan			
	(2) From this plan	. 21(2)		

	Schedule H (F	Form 5500) 2023	Page 4 -		
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Dos	t III Association Chimism							
	t III Accountant's Opinion							
3	Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached. Complete line 3d if an opinion is not attached.	tached	to this	s Form	1 5500.			
a	The attached opinion of an independent qualified public accountant for this plan is (see instructions)	tions).						
	(1) \(\begin{array}{c}\) Unmodified (2) \(\begin{array}{c}\) Qualified (3) \(\begin{array}{c}\) Disclaimer (4) \(\begin{array}{c}\) Adverse							
b	Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the							
	audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.							
	(1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d) (3) X neither DOL Re	gulatior	1 2520.	103-8 r	nor DOL Regulation 2520.103-12(d).			
C	Enter the name and EIN of the accountant (or accounting firm) below:							
	(1) Name: WOLF & COMPANY, P.C.				4-2689883			
d	The opinion of an independent qualified public accountant is not attached as part of Schedule							
Day	(1) This form is filed for a CCT, PSA, DCG or MTIA. (2) It will be attached to the	next F	orm 55	500 pu	rsuant to 29 CFR 2520.104-50.			
	t IV Compliance Questions							
4	CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4							
	103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do n		•					
	generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise p	provide						
_	During the plan year:		Yes	No	Amount			
а	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	4-		Х				
b	until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		Λ				
D	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							
	CEOON Doublis (INVALID to also also also	4b		Х				
С	Were any leases to which the plan was a party in default or classified during the year as	40		21				
_	uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		Х				
d	Were there any nonexempt transactions with any party-in-interest? (Do not include	40						
-	transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is							
	checked.)	4d		Х				
е	Was this plan covered by a fidelity bond?	4e		Х				
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that							
	was caused by fraud or dishonesty?	4f		Х				
g	Did the plan hold any assets whose current value was neither readily determinable on							
	an established market nor set by an independent third party appraiser?	4g		Х				
h	Did the plan receive any noncash contributions whose value was neither readily							
	determinable on an established market nor set by an independent third party							
	appraiser?	4h		Х				
1	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is							
	checked, and see instructions for format requirements.)	4i		Х				
J	Were any plan transactions or series of transactions in excess of 5% of the current							
	value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see	4.	Х					
k	instructions for format requirements.)	4j	^					
K	Were all the plan assets either distributed to participants or beneficiaries, transferred	414		Х				
1	to another plan, or brought under the control of the PBGC? Has the plan failed to provide any benefit when due under the plan?	4k 4l		X				
m	If this is an individual account plan, was there a blackout period? (See instructions	71						
	and 29 CFR 2520.101-3.)	4m		х				
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or							
	one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n		Х				
5 a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year	•		Ye	s X No			
	If "Yes," enter the amount of any plan assets that reverted to the employer this year							

Schedule H (Form 5500) 2023

Page 5
5 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.)

5b(1) Name of plan(s)

5b(2) EIN(s)

5b(3) PN(s)

5 c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.)

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

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SCHEDULE H	OTHER RECEIVABLES		STATEMENT 1
DESCRIPTION		BEGINNING	ENDING
OMADA PROGRAM RECEIVABLE	_	32,881.	52,027.
PREPAID INCOME TAXES		10,300.	0.
PREMIUMS RECEIVABLE		10,500.	8,765.
DUE FROM MFSIA		140,292.	244,951.
RISK SHARING ARRANGEMENT RE OTHER ACCOUNTS RECEIVABLE	CEIVABLE	105,464. 1,381.	0. 0.
TOTAL TO SCHEDULE H, LINE 1	B(3) =	300,818.	305,743.
SCHEDULE H	OTHER PLAN LIABILITIE	es	STATEMENT 2
DESCRIPTION		BEGINNING	ENDING
INCOME TAXES PAYABLE	-	0.	15,700.
TOTAL TO SCHEDULE H, LINE 1	_ J	0.	15,700.
SCHEDULE H	OTHER INCOME		STATEMENT 3
DESCRIPTION			AMOUNT
OMADA PROGRAM PERFORMANCE GUARANTEE			50,646. 28,000.
TOTAL TO SCHEDULE H, LINE 2	С		•
		:	78,646.
SCHEDULE H O	THER ADMINISTRATIVE EXF	PENSES	
SCHEDULE H O DESCRIPTION	THER ADMINISTRATIVE EXE	PENSES	78,646.
DESCRIPTION	THER ADMINISTRATIVE EXE	PENSES	78,646. STATEMENT 4 AMOUNT
	THER ADMINISTRATIVE EXF	PENSES	78,646.
DESCRIPTION INCOME TAXES	THER ADMINISTRATIVE EXE	PENSES	78,646. STATEMENT 4 AMOUNT 26,000.

	(b) Employer Identification	(c) Percentage of
(a) Name of Participating Employer	Number	total contributions
Abington Bank	04-1676630	0.85%
Adams Community Bank	04-1851620	0.77%
Athol Savings Bank	04-1046670	0.46%
Atlantic Community Bank	23-2217734	0.00%
Avidia Bank	04-3395834	2.16%
Bank Five	41-2178171	1.58%
Bank Gloucester	04-1371820	0.39%
Bank Of Canton	04-1148230	0.91%
Bank Of Easton	04-1677520	0.08%
Bankprov	04-3497377	1.78%
Baystate Savings Bank	04-1178460	0.47%
Berkshire Bank	04-3312097	8.01%
Bluestone Bank	04-1118820	1.17%
Boston Trust Walden	04-2273811	0.77%
Bristol County Savings Bank	04-3317338	2.67%
Cambridge Savings Bank	04-1145100	0.00%
Canton Cooperative Bank	04-1207730	0.16%
Cape Ann Savings Bank	04-1148820	0.83%
Cape Cod Five Cent Savings	04-1149070	4.68%
Charles River Bank	04-1609550	0.02%
Clinton Savings Bank	04-1185690	0.86%
Coastal Heritage Bank	04-2628271	0.98%
Colonial Federal Savings Bank	04-1983105	0.28%
Commonwealth Coop Bank	04-1465980	0.17%
Connecticut On-Line Computer Center, Inc.	06-0896418	0.00%
Cooperative Banks Employees Re	04-6035593	0.08%
Cornerstone Bank	04-1856390	0.00%
Country Bank For Savings	04-1946610	0.13%
Dean Bank	04-1237280	0.45%
Dedham Institution For Savings	04-1238700	1.57%
Depositors Insurance Fund	04-1647690	0.12%
East Cambridge Savings Bank	04-1269550	1.29%
Easthampton Savings Bank	06-0475460	1.92%
Enterprise Bank	04-2993547	4.44%
Everett Cooperative Bank	04-1294820	0.75%
Fidelity Bank	20-5791745	0.00%
First Financial Trust	04-1332530	0.08%
Florence Bank	04-1332530	0.00%
Greenfield Cooperative Bank	04-1400390	0.57%
Greenfield Savings Bank	81-0669576	1.07%

	(b) Employer Identification	(c) Percentage of
(a) Name of Participating Employer	Number	total contributions
Harborone Bank	04-1123040	2.78%
Harborone Mortgage	04-1123040	0.85%
Haverhill Bank	04-1426920	0.41%
Hingham Institute For Savings	04-1442480	0.89%
Hometown Bank, A Cooperative Bank	04-1953445	0.86%
Institution For Savings	92-1546128	2.79%
Leader Bank	04-3557920	2.96%
Lee Bank	04-3158399	0.65%
Lowell Five Cent Savings Bank	45-3131005	1.98%
Main Street Bank	04-1584100	1.03%
Marblehead Savings Bank	04-1580550	0.36%
Martha'S Vineyard Savings Bank	04-2188463	0.86%
Mass Bankers Association	04-1589780	0.16%
Mass Business Development Corp	04-2163213	0.32%
Mechanics Cooperative Bank	04-1608620	0.05%
Methuen Cooperative Bank	04-0615835	0.13%
Middlesex Federal Savings	04-1618915	0.59%
Middlesex Savings Bank	27-0402195	4.44%
Milford Federal Savings	04-1621330	0.64%
Millbury National Bank	04-1620675	0.08%
Monson Savings Bank	56-2545442	0.04%
Mountain One Bank	04-3413060	1.28%
Mutual One Bank	04-1339820	0.60%
National Grand Bank	04-2832782	0.37%
Needham Bank	04-1655620	3.32%
New England Automated Clearing	04-2514013	0.15%
New Valley Bank And Trust	83-2497911	0.27%
Newburyport Five Cent Savings	04-1669070	1.68%
North Brookfield Savings Bank	04-1677290	0.02%
North Cambridge Coop Bank	04-1677300	0.14%
North Easton Bank	04-1677530	0.00%
North Shore Bank	04-3414678	1.30%
Northeast Retirement Services	04-2686260	0.90%
One United Bank	04-2764211	0.08%
Onelocal Bank	04-2764211	0.67%
Pentucket Bank	04-1715580	0.82%
Reading Cooperative Bank	04-1760720	0.64%
Rockland Trust	04-1782600	11.03%
Rollstone Bank And Trust	04-1328870	0.68%
Savers Bank	04-1853350	0.49%

	(b) Employer Identification	(c) Percentage of
(a) Name of Participating Employer	Number	total contributions
Savings Bank Mutual Life Insurance Company Of Massachusetts	04-3117253	1.42%
Seamans Bank	04-1817540	0.63%
Stonehambank - A Co-Operative Bank	04-1875250	0.68%
Stoughton Cooperative Bank	04-1875980	0.07%
The Cooperative Bank Of Cape Cod	04-1148930	1.48%
The Savings Bank	04-1939290	1.01%
Wakefield Cooperative Bank	04-1939190	0.44%
Walpole Cooperative Bank	04-1943030	0.41%
Washington Savings Bank	04-1949430	0.31%
Watertown Savings Bank	04-1950840	0.88%
Webster Five Bank	04-1953630	1.03%
Westfield Bank	04-3305700	0.00%
Winchester Coop Bank	04-1978070	0.62%
Winchester Savings Bank	04-1978230	0.61%
Winter Hill Bank	04-1980523	0.42%
Wrentham Cooperative Bank	04-1991475	0.15%
Grand Total		100.0%

Efast2 Authorization to File Form 5500 Electronically

Plan Sponsor: Massachusetts Bankers Association Group Insurance Trust

Plan Number: 501

Plan Year-end: 12/31/2023

I/We the undersigned authorize Wolf & Company, P.C. to file Form 5500 Annual Return/Report of Employee Benefit Plan for year ended 12/31/2023 for the Massachusetts Bankers Association Group Insurance Trust. Further, I/We authorize Wolf & Company, P.C. to enter their ID and PIN number as assigned by Efast2.

I/we have also provided to Wolf & Company, P.C. a signed copy of Form 5500 to be attached to the e-file.

Signatures

Plan Administrator

Chad Pook

Date 07/30/2024

Plan Sponsor

Date 7.29.24

SIGN HERE

	(b) Employer Identification	(c) Percentage of
(a) Name of Participating Employer	Number	total contributions
Abington Bank	04-1676630	0.85%
Adams Community Bank	04-1851620	0.77%
Athol Savings Bank	04-1046670	0.46%
Atlantic Community Bank	23-2217734	0.00%
Avidia Bank	04-3395834	2.16%
Bank Five	41-2178171	1.58%
Bank Gloucester	04-1371820	0.39%
Bank Of Canton	04-1148230	0.91%
Bank Of Easton	04-1677520	0.08%
Bankprov	04-3497377	1.78%
Baystate Savings Bank	04-1178460	0.47%
Berkshire Bank	04-3312097	8.01%
Bluestone Bank	04-1118820	1.17%
Boston Trust Walden	04-2273811	0.77%
Bristol County Savings Bank	04-3317338	2.67%
Cambridge Savings Bank	04-1145100	0.00%
Canton Cooperative Bank	04-1207730	0.16%
Cape Ann Savings Bank	04-1148820	0.83%
Cape Cod Five Cent Savings	04-1149070	4.68%
Charles River Bank	04-1609550	0.02%
Clinton Savings Bank	04-1185690	0.86%
Coastal Heritage Bank	04-2628271	0.98%
Colonial Federal Savings Bank	04-1983105	0.28%
Commonwealth Coop Bank	04-1465980	0.17%
Connecticut On-Line Computer Center, Inc.	06-0896418	0.00%
Cooperative Banks Employees Re	04-6035593	0.08%
Cornerstone Bank	04-1856390	0.00%
Country Bank For Savings	04-1946610	0.13%
Dean Bank	04-1237280	0.45%
Dedham Institution For Savings	04-1238700	1.57%
Depositors Insurance Fund	04-1647690	0.12%
East Cambridge Savings Bank	04-1269550	1.29%
Easthampton Savings Bank	06-0475460	1.92%
Enterprise Bank	04-2993547	4.44%
Everett Cooperative Bank	04-1294820	0.75%
Fidelity Bank	20-5791745	0.00%
First Financial Trust	04-1332530	0.08%
Florence Bank	04-1332530	0.00%
Greenfield Cooperative Bank	04-1400390	0.57%
Greenfield Savings Bank	81-0669576	1.07%

	(b) Employer Identification	(c) Percentage of
(a) Name of Participating Employer	Number	total contributions
Harborone Bank	04-1123040	2.78%
Harborone Mortgage	04-1123040	0.85%
Haverhill Bank	04-1426920	0.41%
Hingham Institute For Savings	04-1442480	0.89%
Hometown Bank, A Cooperative Bank	04-1953445	0.86%
Institution For Savings	92-1546128	2.79%
Leader Bank	04-3557920	2.96%
Lee Bank	04-3158399	0.65%
Lowell Five Cent Savings Bank	45-3131005	1.98%
Main Street Bank	04-1584100	1.03%
Marblehead Savings Bank	04-1580550	0.36%
Martha'S Vineyard Savings Bank	04-2188463	0.86%
Mass Bankers Association	04-1589780	0.16%
Mass Business Development Corp	04-2163213	0.32%
Mechanics Cooperative Bank	04-1608620	0.05%
Methuen Cooperative Bank	04-0615835	0.13%
Middlesex Federal Savings	04-1618915	0.59%
Middlesex Savings Bank	27-0402195	4.44%
Milford Federal Savings	04-1621330	0.64%
Millbury National Bank	04-1620675	0.08%
Monson Savings Bank	56-2545442	0.04%
Mountain One Bank	04-3413060	1.28%
Mutual One Bank	04-1339820	0.60%
National Grand Bank	04-2832782	0.37%
Needham Bank	04-1655620	3.32%
New England Automated Clearing	04-2514013	0.15%
New Valley Bank And Trust	83-2497911	0.27%
Newburyport Five Cent Savings	04-1669070	1.68%
North Brookfield Savings Bank	04-1677290	0.02%
North Cambridge Coop Bank	04-1677300	0.14%
North Easton Bank	04-1677530	0.00%
North Shore Bank	04-3414678	1.30%
Northeast Retirement Services	04-2686260	0.90%
One United Bank	04-2764211	0.08%
Onelocal Bank	04-2764211	0.67%
Pentucket Bank	04-1715580	0.82%
Reading Cooperative Bank	04-1760720	0.64%
Rockland Trust	04-1782600	11.03%
Rollstone Bank And Trust	04-1328870	0.68%
Savers Bank	04-1853350	0.49%

	(b) Employer Identification	(c) Percentage of
(a) Name of Participating Employer	Number	total contributions
Savings Bank Mutual Life Insurance Company Of Massachusetts	04-3117253	1.42%
Seamans Bank	04-1817540	0.63%
Stonehambank - A Co-Operative Bank	04-1875250	0.68%
Stoughton Cooperative Bank	04-1875980	0.07%
The Cooperative Bank Of Cape Cod	04-1148930	1.48%
The Savings Bank	04-1939290	1.01%
Wakefield Cooperative Bank	04-1939190	0.44%
Walpole Cooperative Bank	04-1943030	0.41%
Washington Savings Bank	04-1949430	0.31%
Watertown Savings Bank	04-1950840	0.88%
Webster Five Bank	04-1953630	1.03%
Westfield Bank	04-3305700	0.00%
Winchester Coop Bank	04-1978070	0.62%
Winchester Savings Bank	04-1978230	0.61%
Winter Hill Bank	04-1980523	0.42%
Wrentham Cooperative Bank	04-1991475	0.15%
Grand Total		100.0%

Massachusetts Bankers Association Group Insurance Trust

Schedule H, Line 4j - Schedule of Reportable Transactions

E.I.N. 04-2628271

See independent auditor's report.

Plan Number 501

Year Ended December 31, 2023

pa	Identity of arty involved	Description of asset (include interest rate and maturity in case of a loan)	Purchase price	Selling price	Lease rental	Expense incurred with transaction	Cost of asset	Current value of asset on transaction date	Net gain or (loss)
Category (1)	- A single transaction in excess	of 5% of plan assets:							
Salem Five B	ank	-Maturity of CD, .49%, due 3/31/23		\$200,000					
	- A series of transactions with the securities and aggregating to m	he same person involving property ore than 5% of plan assets:							
None									
Category (3)	- A series of securities transacti	ions in excess of 5% of plan assets:							
None									
Category (4)	- A single transaction with the s	ame person in excess of 5% of plan assets.							
None									