## 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 1210-0089

2018

This Form is Open to Public Inspection

Part I	Annual Report Id	lentification Information							
For calenda	ar plan year 2018 or fisc	cal plan year beginning 07/01/2018	and ending 06/30/2019						
A This retu	urn/report is for:	x a multiemployer plan	a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)						
<b>B</b> This retu	urn/report is:	the first 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			<b>×</b>				
<b>D</b> Check box if filing under:		Form 5558	automatic extension	the	e DFVC program				
		special extension (enter description	n)						
Part II	Part II Basic Plan Information—enter all requested information								
1a Name of plan					Three-digit plan	501			
BUFFALO	LABORERS WELFARE	E FUND		4.0	number (PN) ▶				
				10	1c Effective date of plan 06/01/1956				
Mailing City or	address (include room, town, state or province,	er, if for a single-employer plan) , apt., suite no. and street, or P.O. Box) , country, and ZIP or foreign postal code		2b Employer Identification Number (EIN) 16-0806902					
THOMAS L	OF BUFFALO LABOR PANEK	ERS' WELFARE FUND		2c	Plan Sponsor's tele number 716-894-8061	phone			
25 TYROL DR STE 200 CHEEKTOWAGA, NY 14227-2715			DR STE 200 DWAGA, NY 14227-2715	2d	2d Business code (see instructions) 561110				

## Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Signature of plan administrator	1/07/2020	John J Massaro  Enter name of individual signing as plan administrator
SIGN	orginature of plant duminion area	1/07/2020	Nickolaus Osinski
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
HEKE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2018) v. 171027

Page 2 Form 5500 (2018) **3a** Plan administrator's name and address X Same as Plan Sponsor **3b** Administrator's EIN

			Administrator's telephone number		
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the last reter the plan sponsor's name, EIN, the plan name and the plan number from the last rete		4b EIN		
a C	Sponsor's name Plan Name		4d PN		
5	Total number of participants at the beginning of the plan year		5	1795	
6	Number of participants as of the end of the plan year unless otherwise stated (welfare pla 6a(2), 6b, 6c, and 6d).	ns complete only lines 6a(1),			
a(	(1) Total number of active participants at the beginning of the plan year		6a(1)	636	
a(	(2) Total number of active participants at the end of the plan year		6a(2)	668	
b	Retired or separated participants receiving benefits		6b	196	
С	Other retired or separated participants entitled to future benefits		6c	61	
d	Subtotal. Add lines 6a(2), 6b, and 6c		6d	925	
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	S	6e	48	
f	Total. Add lines <b>6d</b> and <b>6e</b>		6f	973	
g	Number of participants with account balances as of the end of the plan year (only defined complete this item)		6g		
h	Number of participants who terminated employment during the plan year with accrued belless than 100% vested		6h		
7	Enter the total number of employers obligated to contribute to the plan (only multiemploye	r plans complete this item)	7	139	
b	If the plan provides pension benefits, enter the applicable pension feature codes from the  If the plan provides welfare benefits, enter the applicable welfare feature codes from the L  4A 4B 4C	ist of Plan Characteristics Codes	s in the instruction		
	(1)         X         Insurance         (1)           (2)         Code section 412(e)(3) insurance contracts         (2)           (3)         X         Trust         (3)           (4)         General assets of the sponsor         (4)	enefit arrangement (check all that Insurance Code section 412(e)(3) Trust General assets of the sp	insurance contrac		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and,		per attached. (Se	e instructions)	
а	(1) R (Retirement Plan Information) (1) (2) MB (Multiemployer Defined Benefit Plan and Certain Money (2)	ral Schedules  H (Financial Inform I (Financial Inform A (Insurance Inform	nation – Small Pla	n)	
	Purchase Plan Actuarial Information) - signed by the plan actuary  (4)  (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary  (5)  (6)	C (Service Provide D (DFE/Participati G (Financial Trans	er Information) ng Plan Information	,	

Form 5500 (2018)

Page 3

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)							
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)							
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)							
11c Enter the Receipt Confirmation Code for the 2018 Form M-1 annual report. If the plan was not required to file the 2018 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)  Receipt Confirmation Code							

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

2018

				Inspection			
For calendar plan year 20	18 or fiscal plan	year beginning 07/01/2018		and en	ding 06/3	0/2019	
A Name of plan BUFFALO LABORERS W	/ELFARE FUNI	D.		B Three-digit plan number (PN) 501			
C Plan sponsor's name a TRUSTEES OF BUFFALO				yer Identific 0806902	ation Number (	EIN)	
Part I Informat on a separa	mation for each contract e A.						
1 Coverage Information:							
(a) Name of insurance ca		RPORATION					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate num persons covered at			Policy or co	•
(5) EIIV	code	identification number	policy or contract		(f)	From	<b>(g)</b> To
16-1483784	47034	31709	424 07/01/2018		8	06/30/2019	
2 Insurance fee and come descending order of the		ation. Enter the total fees and total	commissions paid. Lis	t in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comm			<b>(b)</b> To	tal amount	of fees paid	
		80098					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all p	ersons).			
AEBLYAND ASSOCIATES		nd address of the agent, broker, o	or other person to whom NECA STREET	commissi	ions or fees	were paid	
AEBLIAND ASSOCIATES	INSURANCE		ENECA, NY 14224				
(b) Amount of sales ar	nd base	Fees	and other commissions	s paid			
commissions pai	id	(c) Amount	(0	d) Purpose	9		(e) Organization code
	80098	0					3
	(a) Name a	nd address of the agent, broker, c	or other person to whom	commissi	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fees	and other commissions	s paid			
commissions pai		(c) Amount	(0	d) Purpose	9		(e) Organization code
For Demonstrate Daylor	n Ant Nation	and the Instructions for Form 55				0-1	Iula A (Farm FF00) 2049

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (f) Amount of sales and base commissions paid  (e) Organization code  (g) Amount of sales and base commissions paid  (g) Amount of sales and base commissions or fees were paid  (g) Amount of sales and base commissions paid  (h) Amount of sales and base c			
		From and other constitutions and	(-)
			Organization
commissions paid	(C) Amount	(a) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		·	
	(c) Amount	(d) Purpose	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
	(c) Amount	(d) Purpose	
•			
(a) Na	The standard of the stand business		
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
			Organization
commissions paid	(0,1	(a) supers	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase			(e)
(b) Amount of sales and base commissions paid			(e) Organization code
			Organization

Part II		II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts v	vith each carrier may be	e treated as a	a unit for purposes of
		this report.				
		ent value of plan's interest under this contract in the general account at year			4	
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co		<del> </del>	6d	
		retention of the contract or policy, enter amount.			<b>0</b> 4	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	ating plan, chec	ck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	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)	<u>.</u>		
		(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)			
		<b>&gt;</b>				
		(6)Total additions		<u> </u>	7c(6)	
	ď	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
	_	(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Pa	art	Ш	Welfare Benefit Contract Informa	ation				
			If more than one contract covers the same					
			the information may be combined for report employees, the entire group of such individ					
Ω	Don	ofit o	nd contract type (check all applicable boxes)		arrier may be	treated do a drift for p	urposco or t	ino report.
O		_		_ —	- ٦	1		al 🗆
	a [		ealth (other than dental or vision)	<b>b</b> Dental	_	Vision		d Life insurance
	е	Te	emporary disability (accident and sickness)	<b>f</b> Long-term disabili	ity <b>g</b>	Supplemental unem	ployment	<b>h</b> X Prescription drug
	i	St	op loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity contract
	m	O	ther (specify)					
	L							
9	Ехре	erien	ce-rated contracts:					
	a	Prem	iums: (1) Amount received		. 9a(1)			
		(2) li	ncrease (decrease) in amount due but unpaid	b	. 9a(2)			
		(3) li	ncrease (decrease) in unearned premium res	serve	. 9a(3)			
		(4) E	Earned ((1) + (2) - (3))				. 9a(4)	
	b	Ben	efit charges (1) Claims paid		. 9b(1)			
		(2) li	ncrease (decrease) in claim reserves		. 9b(2)			
		(3) li	ncurred claims (add (1) and (2))				. 9b(3)	
		` '	Claims charged				. 9b(4)	
	С	Ren	nainder of premium: (1) Retention charges (c	n an accrual basis)				
			(A) Commissions					
			(B) Administrative service or other fees					
			(C) Other specific acquisition costs					
			(D) Other expenses					
			(E) Taxes		9C(1)(E)			
			(F) Charges for risks or other contingencies.		9c(1)(F)			
			(G) Other retention charges				0-(4)(11)	A .
			(H) Total retention				9c(1)(H)	)
			Dividends or retroactive rate refunds. (These	_	_		• • •	
	d		us of policyholder reserves at end of year: (1					
		` '	Claim reserves				. 9d(2)	
	_	` '	Other reserves				. 9d(3)	
10	<u>e</u>		dends or retroactive rate refunds due. (Do n	ot include amount entere	a in line 9c(2)	.)	. 9e	
10	_		erience-rated contracts:				100	2000000
	a		al premiums or subscription charges paid to c				. 10a	3280633
	b		e carrier, service, or other organization incur ntion of the contract or policy, other than rep	, ,		•	. 10b	
	Spe		nature of costs.	Sited iii i ait i, iiie 2 abov	ve, report arrie	, unit		
	-	_						
Pa	art	IV	Provision of Information					
			insurance company fail to provide any inform	nation necessary to comp	lete Schedule	Α? Π	Yes	X No
			nswer to line 11 is "Yes," specify the informat		note Contenuit	/ · · · · · · · · · · · · · · · · · · ·		<u> </u>
14	ıı t	ne al	iswer to line it is ites, specily 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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2018

This Form is Open to Public Inspection

		pursuant to i	_1115A 3ection 103(a)(z)	•			Inspection	
For calendar plan year 20	18 or fiscal plar	year beginning 07/01/2018		and en	ding 06/30/2019	9		
A Name of plan BUFFALO LABORERS W	/ELFARE FUNI	D .			e-digit number (PN)	•	501	
	C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES OF BUFFALO LABORERS' WELFARE FUND			D Emplo	(EIN)			
	ning Insurance Contract . Individual contracts grouped a							
1 Coverage Information:								
(a) Name of insurance ca		COMPANY						
	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or c	ontract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	l	<b>(g)</b> To	
06-1050034	93629	069020	0		07/01/2018		06/30/2019	
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tot	al commissions paid. Li	ist in line 3	the agents, broke	rs, and c	ther persons in	
(a) Total a	amount of comm	nissions paid		<b>(b)</b> To	otal amount of fees	s paid		
3 Persons receiving com		ees. (Complete as many entries			. ,			
	(a) Name a	nd address of the agent, broker,	or other person to whor	m commiss	ions or fees were	paid		
(b) Amount of sales ar	nd base	Fee	es and other commission	commissions paid				
commissions pa	id	(c) Amount		(d) Purpose	е		(e) Organization code	
	(a) Name a	nd address of the agent, broker,	or other person to whor	m commiss	ions or fees were	paid		
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code	
							<del>• • • • • • • • • • • • • • • • • • • </del>	

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (f) Amount of sales and base commissions paid  (e) Organization code  (g) Amount of sales and base commissions paid  (g) Amount of sales and base commissions or fees were paid  (g) Amount of sales and base commissions paid  (h) Amount of sales and base c			
		From and other constitutions and	(-)
			Organization
commissions paid	(C) Amount	(a) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		·	
	(c) Amount	(d) Purpose	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
	(c) Amount	(d) Purpose	
•			
(a) Na	The standard of the stand business		
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
			Organization
commissions paid	(0,1	(a) supers	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase			(e)
(b) Amount of sales and base commissions paid			(e) Organization code
			Organization

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts wi	th each carrier ma	y be treated as a uni	it for purposes of
4	Cur	ent value of plan's interest under this contract in the general account at year $\epsilon$	end		. 4	
		ent value of plan's interest under this contract in separate accounts at year er			. 5	
		tracts With Allocated Funds:			1	
	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 con				
		retention of the contract or policy, enter amount.			. 6d	
		Specify nature of costs				
	е	Type of contract: (1)  individual policies (2)  group deferred	annuity			
			amany			
		(3) other (specify)				
				_		
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan, check	here		
7	Cor	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separa	ate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	te participation g	uarantee		
		(3) X guaranteed investment (4) other				
		(b) M guarantood invocation (1) auto.				
	b	Balance at the end of the previous year			. 7b	6636703
	С	Additions: (1) Contributions deposited during the year			500000	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)		168027	
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>)</b>				
		(6)Total additions			7c(6)	668027
	Ы	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	7304730
	e	Deductions:			74	
	C		7e(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account				
		(4) Other (specify below)	7e(4)			
		<b>)</b>				
		(5) Total deductions			7e(5)	

Balance at the end of the current year (subtract line 7e(5) from line 7d) .....

7304730

P	art	III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individ	group	of e	ses if such	h contrac	cts are ex	pe	rience-rated as a uni	t. Where c	ontract	s cover individual	
8	Ben	efit a	nd contract type (check all applicable boxes)							·				_
	а						С		Vision		d□	Life insurance		
	e [	=	emporary disability (accident and sickness)	f		ng-term di	icability	g		Supplemental unem	nlovment	느	Prescription drug	
		_		: ⊨	_	_	-		_		pioyinent			
	1		op loss (large deductible)	J L	HIV	10 contrad	Ct	K		PPO contract		' 📙	Indemnity contract	
	m	0	ther (specify)											
_														_
9	•		ce-rated contracts:					0 (4)				_		
	а		iums: (1) Amount received				-	9a(1)						
			ncrease (decrease) in amount due but unpaid					9a(2) 9a(3)						
		` '	ncrease (decrease) in unearned premium res								02(4)			_
	b	. ,	Earned ( <b>(1) + (2) - (3)</b> )efit charges (1) Claims paid					9b(1)	T		. 9a(4)			
			ncrease (decrease) in claim reserves											
			ncurred claims (add <b>(1)</b> and <b>(2)</b> )						- 1		. 9b(3)			_
			Claims charged								9b(4)			_
	С	` '	nainder of premium: (1) Retention charges (o											
			(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)			1			
			(H) Total retention			_		_			. 9c(1)(H	l)		
			Dividends or retroactive rate refunds. (These			1-1		-						
	d	Stat	tus of policyholder reserves at end of year: (1	) Amo	ount l	held to pr	ovide be	enefits afte	er r	retirement				
		` '	Claim reserves								. 9d(2)			_
		` '	Other reserves											_
10			dends or retroactive rate refunds due. (Do no	ot inci	lude a	amount e	ntered ir	1 line 9c(2	<b>2)</b> .)	)	. 9e			
10	_		erience-rated contracts: al premiums or subscription charges paid to c	orrior							. 10a			_
	a		•								. Iva			-
	<b>b</b> Spe	rete	e carrier, service, or other organization incurnation of the contract or policy, other than reponenture of costs.								. 10b			
Р	art	V	Provision of Information											_
11	Dio	the	insurance company fail to provide any inform	nation	nece	essary to	complete	e Schedul	le /	A?	Yes	No	)	
12	l If t	he ar	nswer to line 11 is "Yes," specify the informati	ion no	ot pro	ovided.								_

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

2018

This Form is Open to Public

pursuant to ERISA section 103(a)(2). Inspe								
For calendar plan year 20	18 or fiscal plar	year beginning 07/01/2018		and en	iding 06/3	0/2019		
A Name of plan BUFFALO LABORERS W	/ELFARE FUNI	D		<b>B</b> Thre	e-digit number (PN	N) •	501	
C Plan sponsor's name a TRUSTEES OF BUFFALO			D Employer Identification Number (EIN) 16-0806902					
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca GUARDIAN INSURANCE	rrier							
(b) EIN (c) NAIO		(d) Contract or identification number	(e) Approximate nu persons covered a			•	ontract year I	
(5) EIN	code		policy or contrac		(f)	From	<b>(g)</b> To	
13-5123390 64246		00554857	470	)	12/01/2018	8	06/30/2019	
2 Insurance fee and come descending order of the		ation. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents,	brokers, and of	ther persons in	
(a) Total a	amount of comm			<b>(b)</b> To	otal amount	of fees paid		
		2785						
3 Persons receiving com		ees. (Complete as many entries						
0		nd address of the agent, broker,		m commiss	ions or fees	were paid		
SUMMIT CONSULTANTS	& ADVISORS		ILLIAMS ROAD RA FALLS, NY 14304					
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid				
commissions pai		(c) Amount			(e) Organization code			
	2785							
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code	

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(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	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts v	vith each carrier may be	e treated as a	a unit for purposes of
		this report.				
		ent value of plan's interest under this contract in the general account at year			4	
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co		<del> </del>	6d	
		retention of the contract or policy, enter amount.			<b>0</b> 4	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	ating plan, chec	ck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	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)	<u>.</u>		
		(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)			
		<b>&gt;</b>				
		(6)Total additions		<u> </u>	7c(6)	
	ď	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
	_	(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

If more than one contract covers the same group of employees of the same employee (s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.    Benefit and contract type (check all applicable boxes)   a	P	art II	I	Welfare Benefit Contract Informa										
a Health (other than dental or vision)  b Dental  c Vision  d V Life insurance  h Prescription drug  i Stop loss (large deductible)  j HMO contract  k PPO contract  l Indemnity contract  m Other (specify)  PExperience-rated contracts:  a Premiums: (1) Amount received				the information may be combined for report	ing p	urp	oses if such co	ontracts	are exp	oer	ience-rated as a unit.	Where c	ontrac	ts cover individual
e Temporary disability (accident and sickness) f Long-term disability g Supplemental unemployment h Prescription drug i Stop loss (large deductible) j HMO contract k PPO contract I I Indemnity contract m Other (specify)    9 Experience-rated contracts:  a Premiums: (1) Amount received	8	Benef	fit aı	nd contract type (check all applicable boxes)										
i Stop loss (large deductible) j HMO contract k PPPO contract  m Other (specify)   Sexperience-rated contracts:  a Premiums: (1) Amount received.  (2) Increase (decrease) in amount due but unpaid		а	He	alth (other than dental or vision)	b	D	ental		С		Vision		d X	Life insurance
i Stop loss (large deductible) j HMO contract k PPPO contract  m Other (specify)   Sexperience-rated contracts:  a Premiums: (1) Amount received.  (2) Increase (decrease) in amount due but unpaid		е $\Box$	Те	mporary disability (accident and sickness)	f	Īμ	ong-term disal	oility	g	Ī	Supplemental unemp	loyment	h∏	Prescription drug
## District Specify  ## Distr		ιΗ			ı È	=	-	,				,	ıΗ	, ,
9 Experience-rated contracts: a Premiums: (1) Amount received		. H			, <sub>[</sub>	」∵	WO CONTIACT		., Γ		110 contract		•⊔	macrimity contract
a Premiums: (1) Amount received		m	Ot	ner (specify)										
a Premiums: (1) Amount received	0		ione	as vated contracts.										
(2) Increase (decrease) in amount due but unpaid	Э	•							2/1)	T			_	
(3) Increase (decrease) in unearned premium reserve				( )									-	
(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)		,	,							1				
b Benefit charges (1) Claims paid												9a(4)		
(2) Increase (decrease) in claim reserves		- `	,							T		σα( .)		
(3) Incurred claims (add (1) and (2))				- · · · · · · · · · · · · · · · · · · ·				_						
(4) Claims charged		•	,	` '								9b(3)		
(A) Commissions		•	,	, , , , , , , , , , , , , , , , , , , ,							ħ.			
(B) Administrative service or other fees		C	, Rem	nainder of premium: (1) Retention charges (o	n an	acc	rual basis)				<u>-</u>			
(C) Other specific acquisition costs  (D) Other expenses  (E) Taxes  (F) Charges for risks or other contingencies  (G) Other retention charges  (H) Total retention  (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)  (2) Claim reserves at end of year: (1) Amount held to provide benefits after retirement  (2) Claim reserves  (3) Other reserves  (3) Other retroactive rate refunds due. (Do not include amount entered in line 9c(2).)  (4) Nonexperience-rated contracts:  (5) Total premiums or subscription charges paid to carrier  (6) Total premiums or subscription incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			(	(A) Commissions				9с	(1)(A)					
(D) Other expenses			(	(B) Administrative service or other fees				9с	(1)(B)					
(E) Taxes			(	(C) Other specific acquisition costs										
(F) Charges for risks or other contingencies			(	(D) Other expenses										
(G) Other retention charges				• •										
(H) Total retention				-				_						
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)				. ,				<u> </u>			T	0. (4)(11		
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1)  (2) Claim reserves 9d(2)  (3) Other reserves 9d(3)  E Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e  10 Nonexperience-rated contracts:  a Total premiums or subscription charges paid to carrier 10a 3669  b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount 10b				` '									)	
(2) Claim reserves							_		_		i i			
(3) Other reserves				• • •	•		•				ħ			
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)  10 Nonexperience-rated contracts:  a Total premiums or subscription charges paid to carrier		,	` '								ļ ·			
10 Nonexperience-rated contracts:  a Total premiums or subscription charges paid to carrier		,	` '											
Total premiums or subscription charges paid to carrier	10				ot inc	ciuae	e amount ente	rea in i	ne <b>9c(2</b> )	<b>)</b> .)		96		
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	10				orrio	_					Г	100		2660
retention of the contract or policy, other than reported in Part I, line 2 above, report amount		_										IVa		30093
Specify nature of costs.		r	retei	ntion of the contract or policy, other than repo		•	•				'	10b		
	_	- wt 11	,	Dravision of Information										
Deat IV Drawinian of Information														
Part IV Provision of Information							-	nplete S	Schedule	e A	\?	Yes	X N	io
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	12	If the	e an	swer to line 11 is "Yes," specify the informati	on n	ot p	rovided.							

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

2018

pursuant to ERISA section 103(a)(2).  Inis Form is Operation 103(b)(2).  Inspection 103(b)(2).								
For calendar plan year 20	18 or fiscal pla	an year beginning 07/01/2018		and en	nding 06/3	0/2019		
A Name of plan BUFFALO LABORERS W	/ELFARE FUN	ND			e-digit number (PN	N) <b>•</b>	501	
C Plan sponsor's name a TRUSTEES OF BUFFALO					oyer Identifica 0806902	ation Number	(EIN)	
on a separa		rning Insurance Contract  A. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca BLUE CROSS BLUE SHIE								
		(d) Contract or	(e) Approximate nu persons covered a			Policy or c	ontract year	
		identification number	policy or contract		(f)	From	<b>(g)</b> To	
16-1105741	55204	9990214	54		07/01/2018	3	06/30/2019	
2 Insurance fee and com- descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents,	brokers, and o	other persons in	
(a) Total amount of commissions paid				<b>(b)</b> To	otal amount	of fees paid		
					0			
3 Persons receiving com	missions and	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 whor	n commiss	ions or fees	were paid		
AEBLY & ASSOCIAED, IN	C.		SENECA STREET T SENECA, NY 14224					
(b) Amount of sales ar	nd base	Fe	ees and other commissions paid					
commissions pa		(c) Amount	(d) Purpose				(e) Organization code	
	9188						3	
	(a) Name	and address of the agent, broke	r. or other person to whor	n commiss	ions or fees	were paid		
	(a)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
(b) Amount of sales ar	nd base	Ę	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code	

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(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	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts v	vith each carrier may be	e treated as a	a unit for purposes of
		this report.				
		ent value of plan's interest under this contract in the general account at year			4	
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co		<del> </del>	6d	
		retention of the contract or policy, enter amount.			<b>0</b> 4	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	ating plan, chec	ck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	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)	<u>.</u>		
		(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)			
		<b>&gt;</b>				
		(6)Total additions		<u> </u>	7c(6)	
	ď	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
	_	(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Ρ	art III								
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ing purpo	ses if such cont	racts are exp	peri	ence-rated as a unit. Where co	ontrac	ts cover individual
8	Benefi	t and contract type (check all applicable boxes)							
	a X	Health (other than dental or vision)	<b>b</b> De	ental	С	١	√ision	d□	Life insurance
	е ⊟	Temporary disability (accident and sickness)	f 🖺 Lo	ong-term disabili	ty <b>g</b>	Ξ,	Supplemental unemployment	h X	Prescription drug
	; H	Stop loss (large deductible)		MO contract			PPO contract	. [.]	Indemnity contract
	'		<b>J</b> 🔼 '''	vio contract	N_	ַ ' '	- PO Contract	•⊔	indemnity contract
	m _	Other (specify)							
_		and a material according at a							
9	•	ence-rated contracts:			00(1)	1		-	
		emiums: (1) Amount received 2) Increase (decrease) in amount due but unpaid						_	
	,	3) Increase (decrease) in amount due but unpaid 3) Increase (decrease) in unearned premium res				-		-	
		l) Earned ((1) + (2) - (3))					9a(4)		
	_ `	Benefit charges (1) Claims paid				Τ			
		2) Increase (decrease) in claim reserves			(-)				
	,	B) Incurred claims (add <b>(1)</b> and <b>(2)</b> )					9b(3)		
	•	l) Claims charged							
	C F	Remainder of premium: (1) Retention charges (c	n an accr	rual basis)					
		(A) Commissions			9c(1)(A)				
		(B) Administrative service or other fees							
		(C) Other specific acquisition costs							
		(D) Other expenses						_	
		(E) Taxes				-			
		(F) Charges for risks or other contingencies			0 (4)(0)			_	
		(G) Other retention charges					0-/4\/II		
	,	(H) Total retention		_	_			)	
		2) Dividends or retroactive rate refunds. (These							
		Status of policyholder reserves at end of year: (1	•	•					
	`	2) Claim reserves							
	,	Other reserves							
10		experience-rated contracts:	ot include	amount entered	2 111 1111 <del>0</del> <b>30(2</b> )	<b>.)</b> .) .	3 <del>c</del>		
		otal premiums or subscription charges paid to c	arrier				10a		118595
	_	the carrier, service, or other organization incur							110000
	re	etention of the contract or policy, other than reprint place of costs.	, ,				•		
	Specii	y nature or costs.							
P	art IV	Provision of Information							
					lata Oat III		о П v <sub>oo</sub>	П ы	•
		he insurance company fail to provide any inform			iete Schedule	e A	? Yes	N	U
12	If the	e answer to line 11 is "Yes," specify the informat	ion not pr	ovided.					

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

2018

	Inspection						
For calendar plan year 20°	18 or fiscal plan	year beginning 10/01/2018		and en	ding 06/3	0/2019	
A Name of plan BUFFALO LABORERS W	ELFARE FUNI			B Three	e-digit number (PI	N) •	501
C Plan sponsor's name a TRUSTEES OF BUFFALC					yer Identific 0806902	ation Number (	EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance car THE HARTFORD	rrier						
(c) NAI		(d) Contract or	(e) Approximate nur			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To
06-0838648 70815		872808G	609		07/01/2018	8	12/01/2018
2 Insurance fee and communication descending order of the		tion. Enter the total fees and total	l commissions paid. Lis	st in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comn	·		<b>(b)</b> To	otal amount	of fees paid	
		2736					
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all p	ersons).			
		nd address of the agent, broker, o		commiss	ions or fees	were paid	
WALSH JONES AGENCY	INC		NECA STREET BENECA, NY 14224				
(b) Amount of sales an	nd base	Fees	and other commissions	s paid			
commissions pai	d	(c) Amount	(0		(e) Organization code		
	2736						3
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commissi	ions or fees	were paid	
(b) Amount of sales an	id base	Fees	and other commissions	s paid			
commissions pai		(c) Amount	(0	d) Purpose	e		(e) Organization code
For Bonney and Body of	n Ant Notice	see the Instructions for Form Ef	-00			0-1	Iula A (Farm FF00) 2019

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(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	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts v	vith each carrier may be	e treated as a	a unit for purposes of
		this report.				
		ent value of plan's interest under this contract in the general account at year			4	
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co		<del> </del>	6d	
		retention of the contract or policy, enter amount.			<b>0</b> 4	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	ating plan, chec	ck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	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)	<u>.</u>		
		(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)			
		<b>&gt;</b>				
		(6)Total additions		<u> </u>	7c(6)	
	ď	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
	_	(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

P	art II	Welfare Benefit Contract Information If more than one contract covers the same group o the information may be combined for reporting purp employees, the entire group of such individual cont	poses if such contra	acts are expe	erience-rated as a unit	. Where co	ontracts cover individual	
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	Dental	с	Vision		<b>d</b> X Life insurance	
	е	Temporary disability (accident and sickness) <b>f</b>	Long-term disability	g∏	Supplemental unemp	oloyment	h Prescription drug	
	ιĒ		HMO contract	~ '	PPO contract	•	I Indemnity contract	
	<u> </u>	Other (specify)		🗀	• • • • • • • • • • • • • • • • • •			
	m	Other (specify) •						
9	Exnei	erience-rated contracts:						
•		Premiums: (1) Amount received	Г	9a(1)				
		(2) Increase (decrease) in amount due but unpaid	-	9a(2)				
		(3) Increase (decrease) in unearned premium reserve		9a(3)				
	,	(4) Earned ((1) + (2) - (3))	<u> </u>			9a(4)		C
	b	Benefit charges (1) Claims paid		9b(1)		. ,		
	(	(2) Increase (decrease) in claim reserves		9b(2)				
	(	(3) Incurred claims (add (1) and (2))				9b(3)		
	(	(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on an ac	crual basis)					
		(A) Commissions	<del>-</del>	9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs	<u> </u>	9c(1)(C)				
		(D) Other expenses	<u> </u>	9c(1)(D)				
		(E) Taxes	<del>-</del>	9c(1)(E) 9c(1)(F)				
		(F) Charges for risks or other contingencies		9c(1)(G)				
		(G) Other retention charges(H) Total retention	<u> </u>	1		9c(1)(H	1	
		(2) Dividends or retroactive rate refunds. (These amount	_	_			,	
			<u> </u>					
		Status of policyholder reserves at end of year: (1) Amou (2) Claim reserves				9d(1) 9d(2)		
		(3) Other reserves				9d(2)		
		Dividends or retroactive rate refunds due. (Do not include						
10		nexperience-rated contracts:	de amount entereu		)			
		Total premiums or subscription charges paid to carrier				10a	48	808
	b	If the carrier, service, or other organization incurred any retention of the contract or policy, other than reported in	specific costs in co	nnection with	n the acquisition or			
	b Spec	If the carrier, service, or other organization incurred any retention of the contract or policy, other than reported in cify nature of costs.  Provision of Information	specific costs in cor Part I, line 2 above	nnection with , report amo	n the acquisition or unt	10b		
		the insurance company fail to provide any information no	ecessary to comple	te Schedule	А?	Yes	No	
				te Scriedule	Λ:	103		
12	it th	he answer to line 11 is "Yes," specify the information not p	provided. 🕨					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration 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.

**Service Provider Information** 

OMB No. 1210-0110

2018

This Form is Open to Public Inspection.

Pension Benefit Guaranty Corporation	Inspection.
For calendar plan year 2018 or fiscal plan year beginning 07/01/2018	and ending 06/30/2019
A Name of plan	<b>B</b> Three-digit
BUFFALO LABORERS WELFARE FUND	plan number (PN) 501
•	<b>P</b>
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES OF BUFFALO LABORERS' WELFARE FUND	D Employer Identification Number (EIN)
TRUSTEES OF BUFFALO LABORERS WELFARE FUND	16-0806902
Part I Service Provider Information (see instructions)	
1 Information on Persons Receiving Only Eligible Indirect Co	
a Check "Yes" or "No" to indicate whether you are excluding a person from the re	· · · · · · · · · · · · · · · · · · ·
indirect compensation for which the plan received the required disclosures (see	e instructions for definitions and conditions)
<b>b</b> If you answered line 1a "Yes," enter the name and EIN or address of each per received only eligible indirect compensation. Complete as many entries as need	
(b) Enter name and EIN or address of person who pro	vided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who pro	vided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who pro	vided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who pro	vided you disclosures on eligible indirect compensation
PIMCO FUNDS 840 NEWPORT NEWPORT BEA	CENTER DRIVE ACH, CA 92660

33-0629048

Schedule C (Form 5500) 2018	Page <b>2-</b> 1
	of person who provided you disclosures on eligible indirect compensation
PRUDENTIAL RETIREMENT INSURANCE CO.	280 TRUMBALL HARTFORD, CT 06102
06-1050034	
(b) Enter name and EIN or address	of person who provided you disclosures on eligible indirect compensation
40-	
(D) Enter name and EIN or address (	of person who provided you disclosures on eligible indirect compensation
(h) Enter name and EIN or address	of person who provided you disclosures on eligible indirect compensation
(b) Litter flame and Lift of address t	of person who provided you disclosures on engible mained compensation
(b) Enter name and EIN or address of	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

answered	f "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation in person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and EIN or	r address (see instructions)		
THOMAS	L PANEK		SUITE	OL DRIVE 200 TOWAGA, NY 14227		
16-080690	)2					
(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?
30	EMPLOYEE	181658	Yes No X	Yes No	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
GORLICK 13-379082	KRAVITZ AND LISTH	AUS PC	4TH FL	TE STREET OOR ORK, NY 10004		
(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?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	N/A	179886	Yes No X	Yes No	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
TRACY BA			25 TYR SUITE	OL DRIVE		
(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?
30	EMPLOYEE	127304	Yes No X	Yes No	0	Yes No X

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Schedule C (Form 5500) 2018

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Schedule C (Form 5500) 2018
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answered	"Yes" to line 1a above	e, complete as many e	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)	<u> </u>	
JOANNE C	CHIAVETTA		SUITE :	OL DRIVE 200 TOWAGA, NY 14227		
16-080690	2					
(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?
30	EMPLOYEE	81360	Yes No X	Yes No	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
JULIE MUF			SUITE:	OL DRIVE 200 TOWAGA, NY 14227		
(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?
80	EMPLOYEE	76722	Yes No 🛚	Yes No	0	Yes No X
	l	(	a) Enter name and EIN or	address (see instructions)		
PROSKAU	ER ROSE LLP			N TIMES SQUARE ORK, NY 10036		
13-184045	4					
(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?	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?
9	N/A	37857	Yes No X	Yes No	0	Yes No X

Page <b>3</b> -	3
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answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation in the person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
-			(a) Enter name and EIN or	r address (see instructions)		
LABORER	RS NATIONAL HEALTI	H AND SAFETY		RPORATE WOODS Y, NY 12211		
22-311094	¥1					
(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
16	N/A	36056	Yes No 🗵	Yes No	0	Yes No X
			a) Enter name and EIN or	address (see instructions)		
JOE MCC.	ARTHY AND ASSOCI	ATES		SWEGO ROAD POOL, NY 13090		
(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?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount
10	N/A	24871	Yes No 🛚	Yes No	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)	-	
EMPLOYE	EE RESOURCE INC		77 BRC SUITE	DADWAY		
16-141017	79					
(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?
16	N/A	22100	Yes No X	Yes No	0	Yes No X

	Schedule C (Form 550	00) 2018		Page <b>3 -</b> 4		
answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation in the 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	r address (see instructions)		
	I AND MCCORMICK I	LP	369 FR	RAMA BUILDING ANKLIN STREET LO, NY 14202		
16-076548	Ь					
(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?
10	N/A	17500	Yes No 🛚	Yes No	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
ANDCO C	ONSULTING		SUITE	INELAND ROAD 600 IDO, FL 32811		
	_				<u>,                                      </u>	
(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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28	N/A	6750	Yes No 🛚	Yes No	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
M&T BANK	<			AND T PLAZA LO, NY 14203		
16-626570	6					
(b) Service	(c) Relationship to	(d) Enter direct	<b>(e)</b> Did service provider	(f) Did indirect compensation	(g) Enter total indirect	(h) Did the service

receive indirect

compensation? (sources

other than plan or plan

sponsor)

Yes No X

include eligible indirect

compensation, for which the

plan received the required

disclosures?

Yes No

compensation received by

service provider excluding

eligible indirect

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

compensation for which you estimated amount?

provider give you a

formula instead of

an amount or

Yes No X

Code(s)

16

employer, employee organization, or by the plan. If none,

enter -0-.

16818

person known to be

a party-in-interest

N/A

Page <b>3</b> -	5
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answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ich person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	total compensation	
	(a) Enter name and EIN or address (see instructions)						
JBM COM	PUTER CONSULTAN	TS		RTH AMERICAN DRIVE SENECA, NY 14224			
16-117311	8						
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?	
15	N/A	14892	Yes No X	Yes No	0	Yes No X	
		(	a) Enter name and EIN or	address (see instructions)			
PCA CON	SULTING		303 CA SUITE	YUGA ROAD			
26-002277	8						
(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?	
16	N/A	7207	Yes No X	Yes No	0	Yes No X	
		(	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	

Page <b>4</b> -
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# Part I Service Provider Information (continued)

or provides contract administrator, consulting, custodial, investment advisory, investment madvestions for (a) each source from whom the service provider received \$1,000 or more in incorprovider gave you a formula used to determine the indirect compensation instead of an amomany entries as needed to report the required information for each source.	direct compensation and (b) each s	ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(a) Describe the indirect	compensation, including any
(a) Effect famile and Effy (address) of source of malifect compensation	formula used to determine	e the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe 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
	(2) 2	
(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.

D	art II Service Providers Who Fail or Refuse to	Drovido Inform	mation
4			
4	this Schedule.	ach service provide	r 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 <b>6</b> -	l
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Pa	art III	Termination Information on Accountants and Enrolled Act	uaries (see instructions)				
_	Nome	(complete as many entries as needed)	<b>b</b> EIN:				
<u>a</u>	Name:		D EIN:				
d	Position Address		e Telephone:				
u	Addres	55.	e reiepriorie.				
Ex	planation	າ:					
а	Name:		<b>b</b> EIN:				
С	Positio						
d	Addres		e Telephone:				
			·				
Ex	planation	n:					
а	Name:		<b>b</b> EIN:				
С	Positio						
d	Addres	SS:	<b>e</b> Telephone:				
	planation	2.					
LX	φιαιταιτοι	i.					
а	Name:		b EIN:				
C	Positio		U LIIV.				
d	Addres		<b>e</b> Telephone:				
-	, taarot		• receptions.				
Ex	planation	n:					
а	Name:		<b>b</b> EIN:				
С	Positio	n:					
d	Addres	SS:	<b>e</b> Telephone:				
Ex	planation	n:					

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration Panaian Panafit Cuaranty Corporation

Department of Labor

# **Financial Information**

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2018

This Form is Open to Public

<u> </u>	0/2019	
		501
' '		(EIN)
	plan nu	Three-digit plan number (PN)  Employer Identification Number 16-0806902

## Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	198814	70209
<b>b</b> Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1700000	1781000
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	99050	57087
<b>c</b> General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	1965072	371311
(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)	775	775
(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)	8765854	9989097
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	6636703	7304730
(15) Other	1c(15)		

1d Employer-related	d investments:		(a) Beginning of Year	(b) End of Year
(1) Employer se	curities	1d(1)		
(2) Employer rea	al property	1d(2)		
e Buildings and oth	ner property used in plan operation	1e	18331	9496
f Total assets (add	d all amounts in lines 1a through 1e)	1f	19384599	19583705
	Liabilities			
<b>g</b> Benefit claims pa	ayable	1g		
<b>h</b> Operating payab	les	1h	158237	145738
i Acquisition indeb	otedness	1i		
j Other liabilities		1j		
k Total liabilities (a	dd all amounts in lines 1g through1j)	1k	158237	145738
	Net Assets			
I Net assets (subt	ract line 1k from line 1f)	11	19226362	19437967

## Part II Income and Expense Statement

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

	Income		(a) Amount	(b) Total
а	Contributions:			
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	8825128	
	(B) Participants	2a(1)(B)	404848	
	(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)		9229976
b	Earnings on investments:			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	1281	
	(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)	168026	
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		169307
	(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)	327987	
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		327987
	(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)		0
	(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)		0

			(a	<b>a)</b> Am	ount			(b) Tota	al
	(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	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)							95256
С	Other income	. 2c							105606
d	Total income. Add all <b>income</b> amounts in column (b) and enter total	. 2d							9928132
	Expenses								
е	Benefit payment and payments to provide benefits:								
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)			503	86920			
	(2) To insurance carriers for the provision of benefits	2e(2)			393	33331			
	(3) Other	2e(3)				8156			
	(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)							9028407
f	Corrective distributions (see instructions)	2f							0020101
g		. 2g					_		
_	Interest expense	2h							
:	·	2i(1)				0.4.00			
•	Administrative expenses: (1) Professional fees	2i(2)			26	3183			
	(2) Contract administrator fees	0:(0)					_		
	(3) Investment advisory and management fees	0:/4\				6750			
	(4) Other				41	8187			
	(5) Total administrative expenses. Add lines 2i(1) through (4)								688120
J	Total expenses. Add all <b>expense</b> amounts in column (b) and enter total	. 2j							9716527
_	Net Income and Reconciliation	-							
k	Net income (loss). Subtract line 2j from line 2d	2k							211605
ı	Transfers of assets:	01(4)							
	(1) To this plan	21(1)							
	(2) From this plan	. 21(2)							
Pá	art III Accountant's Opinion								
	Complete lines 3a through 3c if the opinion of an independent qualified public attached.	accountant	is attached to	this	Form 5	500. Co	mplete line 3	d if an o	pinion is not
	The attached opinion of an independent qualified public accountant for this pla	an is (see ins	structions):						
	(1) Vunqualified (2) Qualified (3) Disclaimer (4)	Adverse	,						
h	Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.10	<u>⊔</u>  3-8 and/or 1	03-12(d)2				Yes	X	No
	Enter the name and EIN of the accountant (or accounting firm) below:		03 12(u):						1 110
	(1) Name: LUMSDEN & MCCORMICK LLP		(2) EIN:	: 16-0	765486	3			
d	The opinion of an independent qualified public accountant is <b>not attached</b> be	cause:	(-,	.00	. 50-100	•			
	(1) This form is filed for a CCT, PSA, or MTIA. (2) It will be atta		next Form 55	500 pı	ursuant	to 29 C	FR 2520.104	-50.	
Pa	art IV Compliance Questions								
4	CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complet		e lines 4a, 4e	e, 4f, 4	4g, 4h,	4k, 4m,	4n, or 5.		
	During the plan year:				Yes	No		Amoun	ıt
а	Was there a failure to transmit to the plan any participant contributions within	in the time							
	period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction	prior year fa		4a		X			
b	Were any loans by the plan or fixed income obligations due the plan in defar	ult as of the							
	close of the plan year or classified during the year as uncollectible? Disrega secured by participant's account balance. (Attach Schedule G (Form 5500) checked.)	ard participa Part I if "Yes		4b		X			

			Yes	No	Amo	unt
С	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X		
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X		
е	Was this plan covered by a fidelity bond?	4e	Χ			3000000
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		X		
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	X			775
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		X		
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X			
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j	<i>X</i>	X		
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X		
ı	Has the plan failed to provide any benefit when due under the plan?	41		X		
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X		
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				
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? Yes If "Yes," enter the amount of any plan assets that reverted to the employer this year	S X	No			
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identarisferred. (See instructions.)	ntify tl	he plan	(s) to v	vhich assets or liabi	lities were
	5b(1) Name of plan(s)				<b>5b(2)</b> EIN(s)	<b>5b(3)</b> PN(s)
	f the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section for "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan yet.		21.)?	\[ \		Not determined e instructions.)



**CERTIFIED PUBLIC ACCOUNTANTS** 

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### INDEPENDENT AUDITORS' REPORT

The Trustees
Buffalo Laborers' Welfare Fund

We have audited the accompanying statements of net assets available for benefits and statements of benefit obligations of Buffalo Laborers' Welfare Fund (the Fund) as of June 30, 2019 and 2018, and the related statements of changes in net assets available for benefits and statements of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

### **Management's Responsibility for the Financial Statements**

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes 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.

#### **Auditors' Responsibility**

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Fund's preparation and fair presentation of the financial statements 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 Fund's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

## Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of the Fund as of June 30, 2019 and 2018, 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.

lon & McCornick, LLP

December 13, 2019

# **BUFFALO LABORERS' WELFARE FUND**

E.I.N.: 16-0806902 Plan Number: 501 Additional Information

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

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(a) (b) (c)	(c)	(d)	(e)
	Shares/		Current
Identity of Issue Description	Par Value	Cost	Value
Interest Bearing Cash:			
M&T Bank Savings Account	371,311	\$ 371,311	\$ 371,311
Mutual Funds:			
PIMCO All Asset Institutional Fund	169,265	2,176,960	2,087,186
PIMCO Low Duration Fund	593,902	6,292,332	6,014,924
J P Morgan Global Allocation Fund	54,466	1,848,406	1,886,987
		10,317,698	9,989,097
Limited Partnerships:			
Andover Associates, L.P.	750	750	775
Fully Benefit-Responsive Investment Contract:			
Prudential Fixed Rate Fund, 2.80%		7,304,730	7,304,730
Total investments		\$ 17,994,489	\$ 17,665,913

<sup>\*</sup> No investments are with parties-in-interest.