



## ANNUAL MASTER TRUSTEE REPORT

**Reporting period:** Jan. 1 to Dec. 31  
**For the year ended:** \_\_\_\_\_  
**Due date:** April 1  
**Annual report fee:** \$335

**Mail report with payment to:**  
 DCBS — Fiscal Services  
 P.O. Box 14610  
 Salem, OR 97309-0445

You must attach Detail Schedule 1 to this report. You may submit Detail Schedule 1 using the department's form or on a separate typed or computer-produced report.

Submit a copy of the fiscal year's audited financial statements. If the statements were not prepared within six months of the date of this filing, include internally prepared reports through the most recent month's end.

Provider name: \_\_\_\_\_

Contact name: \_\_\_\_\_ Contact phone no.: (     ) \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

### Transaction summary

A. <sup>1</sup> Beginning balance, Jan. 1 .....	\$ _____
B. Current year deposits .....	\$ _____
C. Deposits in transit .....	\$ _____
D. Net recognized gains/losses on sales transactions .....	\$ _____
E. <sup>2</sup> Interest/dividends earned on trust accounts .....	\$ _____
F. <sup>3,4</sup> Trustee, accounting, depository, and investment fees .....	\$( _____ )
G. Taxes paid for the benefit of contract beneficiaries .....	\$( _____ )
H. Withdrawals .....	\$( _____ )
I. Unrecognized gains (losses) as of Dec. 31 .....	\$ _____
J. <sup>5</sup> Ending balance, Dec. 31 .....	\$ _____

<sup>1</sup> Line A must match the ending balance of the previous report.  
<sup>2</sup> Do not include unrecognized gain or loss on Line E.  
<sup>3</sup> Line F must not exceed 2 percent of Line A pursuant to ORS 97.943(9)(a).  
<sup>4</sup> Line F must not exceed the total of Lines D and E pursuant to ORS 97.943(9)(c).  
<sup>5</sup> Line J must match the ending balance of the depository summary on Page 2.

*Continued on Page 2*

<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover    Phone: (     ) _____	
_____ Credit card number	_____ Expiration date
_____ Name of cardholder as shown on credit card	
_____ Cardholder signature	\$ _____ Amount

**Make check or money order payable to the Department of Consumer & Business Services.** If paying by credit card, applicant must sign the credit card information box. Do *not* send cash.

**FISCAL USE ONLY:** 61260/1008



# DETAIL SCHEDULE 1

For the year: \_\_\_\_\_

Name of master trustee:

Name of certified provider:

\_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Phone: (        ) \_\_\_\_\_

Phone: (        ) \_\_\_\_\_

Name of security on deposit or invested

Deposited at (name and address)

Trust amount

\_\_\_\_\_

\_\_\_\_\_

\$ \_\_\_\_\_

\_\_\_\_\_