Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Annual Report Identification Information

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022

Pension Benefit Guaranty Corporation

Part I

HERE

Signature of DFE

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

2022

This Form is Open to Public Inspection

and ending 12/31/2022

Enter name of individual signing as DFE

A This	return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)				
		X a single-employer plan	a DFE (specify	• •	e with the form motidate	,,,,	
R This	return/report is:	the first return/report	the final return	report			
	rotarry oport io.	an amended return/report	a short plan ye	ar return/report (less than 12 mo	nths)		
C If the	plan is a collectively-barg	ained plan, check here		·	₹		
D Chec	k box if filing under:	X Form 5558	automatic exte	the DFVC program			
	J	special extension (enter description	n)	_	_		
E If this	is a retroactively adopted	plan permitted by SECURE Act section	201, check here				
Part II	Basic Plan Infor	mation—enter all requested informatio	n	_			
	ne of plan				1b Three-digit plan	516	
NOKIA	LONG-TERM DISABILIT	Y PLAN			number (PN) ▶ 516 1c Effective date of plan 10/01/1996		
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)					2b Employer Identification Number (EIN) 22-3408857		
NOKIA	OF AMERICA CORPORA	2c Plan Sponsor's telephone number 908-723-9869					
600 MOUNTAIN AVENUE, ROOM 6D-401A MURRAY HILL, NJ 07974					2d Business code (see instructions) 334200		
Caution	: A penalty for the late o	r incomplete filing of this return/repor	t will be assessed	unless reasonable cause is est	ablished.		
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.							
SIGN HERE	Filed with authorized/vali	d electronic signature.	07/28/2023	CAREY SETTLE			
HEKE	Signature of plan adm	inistrator	Date	Enter name of individual signing as plan administrator			
SIGN							
HERE	Signature of employer	/plan sponsor	Date	Enter name of individual signin	g as employer or plan sp	onsor	
SIGN							

Date

Form 5500 (2022) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number 4b EIN If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: а Sponsor's name **4d** PN Plan Name 5 Total number of participants at the beginning of the plan year 7520 5 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 7314 a(1) Total number of active participants at the beginning of the plan year 6a(1) 7309 a(2) Total number of active participants at the end of the plan year 6a(2)168 Retired or separated participants receiving benefits 6b 0 Other retired or separated participants entitled to future benefits..... 7477 Subtotal. Add lines 6a(2), 6b, and 6c. 6d Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested... 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: **b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4F 4H 9a Plan funding arrangement (check all that apply) **9b** Plan benefit arrangement (check all that apply) (1) Insurance (1) Insurance Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts (2) (3) (3) (4) General assets of the sponsor (4) General assets of the sponsor 10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules

b General Schedules

X

H (Financial Information)

A (Insurance Information)

C (Service Provider Information) **D** (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

I (Financial Information – Small Plan)

(1)

(2)

(3)

(4)

(5)

(6)

(1)

(2)

(3)

R (Retirement Plan Information)

actuary

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

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Form 5500 (2022)

Receipt Confirmation Code

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

2022

This Form is Open to Public

						nspection			
For calendar plan year 2	2022 or fiscal pl	an year beginning 01/01/2022		and end	ding 12/3	1/2022			
A Name of plan NOKIA LONG-TERM D	ISABILITY PLA	AN		B Three plan	e-digit number (PN	N) •	516		
C Plan sponsor's name NOKIA OF AMERICA C				D Employer Identification Number (EIN) 22-3408857					
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 of METROPOLITAN LIFE III	carrier	OMPANY							
			(e) Approximate no	umbor of		Policy or co	ntract vear		
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	t end of	(f)	From	(g) To		
13-5581829	65978	0156777	7462	7462		2	12/31/2022		
2 Insurance fee and co- descending order of the		mation. Enter the total fees and t	otal commissions paid. L	ist in line 3 t	the agents,	brokers, and ot	her persons in		
(a) Tota									
		55000					24656		
3 Persons receiving co	mmissions and	fees. (Complete as many entrie	es as needed to report all	persons).					
•		and address of the agent, broke			ons or fees	were paid			
AON CONSULTING INC			10 NETWORK PL CAGO, IL 60673-1298						
(h) Amount of color		F	ees and other commissio	ns paid					
(b) Amount of sales and base commissions paid		(c) Amount		(d) Purpose			(e) Organization code		
	55000	24656	NON-MONETARY COMPENSATION SUPPLEMENTAL COMPENSATION PRODUCER SERVICE FEES MARKETING FEES		3				
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ons or fees	were paid			
	X.,	y ,	,			,			
(b) Amount of sales and base Fees and other commissions paid									
commissions p		(c) Amount		(d) Purpose)		(e) Organization code		

(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Face and other commissions noid	(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, broke	r, 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	
	,	, , , , , , , , , , , , , , , , , , ,	
		Fees and other commissions paid	
(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(2)		, or a more personal materials and a more personal person	
			T
(h) Amount of color and have		Fees and other commissions paid	(e) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	code
•			
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(2)		,	
		Fees and other commissions paid	
(h) Amount of calca and have		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
and the period			

_) f	II Investment and Annuity Centreet Information			
ŀ	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with each	n carrier may be treated as a unit f	or purposes of
		this report.			o. papoodo o.
4	Curr	rent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	rent value of plan's interest under this contract in separate accounts at year e	nd	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 cor	nnection with the acquisi	tion or 6d	
		retention of the contract or policy, enter amount			
		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 termin	ating plan, check here	▶ □	
7			•		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а	- 1	te participation guarante	ee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	0
	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)		
)			
		(6)Total additions		7c(6)	0
	А	Total of balance and additions (add lines 7b and 7c(6)).			0
		Deductions:		74	
	•	(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)		
		(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)			0

P	Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.								
_	_		i contracts with each ca	imer may	be	ireated as a unit for pu	rposes or t	nis repor	<u>. </u>
8	Ben	efit and contract type (check all applicable boxes)				1			
	а	Health (other than dental or vision)	Dental Dental		С	Vision		d Lif	e insurance
	е	Temporary disability (accident and sickness) f	X Long-term disabilit	y !	gΠ	Supplemental unemp	loyment	h Pr	escription drug
	i	Stop loss (large deductible)	HMO contract		k∏	PPO contract		I no	demnity contract
	m	Other (specify)			ш			ш	•
	L	_ office (specify) /							
<u> </u>	Evno	erience-rated contracts:							
9		Premiums: (1) Amount received		02/1)					
	aı			9a(1) 9a(2)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)				-	
		(3) Increase (decrease) in unearned premium reserv	·				02(4)		0
	h	(4) Earned ((1) + (2) - (3))	i	9b(1)			9a(4)		
	b	Benefit charges (1) Claims paid		9b(2)	-				
		(2) Increase (decrease) in claim reserves					9b(3)		0
		(3) Incurred claims (add (1) and (2))							
	_	(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on a		00/1)//					
		(A) Commissions		9c(1)(A					
		(B) Administrative service or other fees		9c(1)(E					
		(C) Other specific acquisition costs		9c(1)(E	-				
		(D) Other expenses		9c(1)(E				_	
		(E) Taxes			-			_	
		(F) Charges for risks or other contingencies		9c(1)(F				_	
		(G) Other retention charges		9c(1)(0			- 4040		
		(H) Total retention	_		_		9c(1)(H))	0
		(2) Dividends or retroactive rate refunds. (These ar	mounts were 📗 paid in	cash, or		credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) A	mount held to provide	benefits a	after	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not i	include amount entered	in line 9	c(2).	.)	9e		
10	No	nexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carr	rier				10a		2313561
	b	If the carrier, service, or other organization incurred	any specific costs in co	onnection	n with	h the acquisition or			
		retention of the contract or policy, other than reporte					10b		
	Spe	cify nature of costs.							
_		Dravisian of Information							
	Part IV Provision of Information								
11	11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
12	12 If the answer to line 11 is "Yes." specify the information not provided.								