For calendar plan year 2023 or fiscal plan year beginning and ending

A This return/report is for:
- ☐ a multiemployer plan
- ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- ☐ a single-employer plan
- ☐ a DFE (specify) ____

B This return/report is:
- ☐ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ☐

D Check box if filing under:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ☐

Part II Basic Plan Information enter all requested information

1a Name of plan

1b Three-digit plan number (PN)

1c Effective date of plan

2a (employer, if for a single-employer plan)

3a	☐ Same as Plan Sponsor	**3b**
		3c number
4 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 name, EIN, the plan name and the plan number from the last return/report:		**4b** EIN
a		**4d** PN
c Plan Name		

5	Total number of participants at the beginning of the plan year	**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**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	

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- ☐ Yes ☐ No

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101- ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 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_____

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.

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

A Name of plan
LOCKHEED MARTIN SPECIALTY COMPONENTS, INC. DENTAL ASSISTANCE PLAN

B Three-digit plan number (PN) 503

C s shown on line 2a of Form 5500
LOCKHEED MARTIN CORPORATION

D Employer Identification Number (EIN)
52-1747835

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 carrier
CONNECTICUT GENERAL LIFE INSURANCE COMPANY AND AFFILIATES

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
59-1031071	67369	3210240	1	01/01/2023	12/31/2023

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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs	**6d**	

e Type of contract: (1) ind 158.18 500.56 Td ( )TjET Q q 131.66 497.08 135 14.28 re W* n BT /TT0 7.98 Tf 162.62 500.56 Td [de

(2) Administration charge made by carrier	**7e(1)**		
(3) Transferred to separate account	**7e(2)**		
(4) Other (specify below)	**7e(3)**		
	7e(4)		
(5) Total deductions		**7e(5)**	
f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		**7f**	

X

0

0

0

604

X