#### 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 6047(e), 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

2009

	, , , , , , , , , , , , , , , , , , , ,				Inis Form is Open to Pu Inspection	IDIIC
Part I	Annual Report Iden	tification Information				
For cale	ndar plan year 2009 or fiscal p	olan year beginning 01/01/2009	_	and ending 12/31/2	2009	
<b>A</b> This	return/report is for:	a multiemployer plan;	a multipl	e-employer plan; or		
		a single-employer plan;	a DFE (s	pecify)		
<b>B</b> This	return/report is:	the first return/report;	the final	return/report;		
		an amended return/report;	a short p	lan year return/report (less t	han 12 months).	
C If the	plan is a collectively-bargaine	ed plan, check here				
	k box if filing under:	☐ Form 5558:	_	c extension;	the DFVC program;	
D Onco	K box ii iiiiiig dildei.	special extension (enter des		,	,	
Dort	II Pacia Blan Inform	nation—enter all requested informa				
Part 1a Nam	ne of plan	Tation—enter all requested informa	ation		<b>1b</b> Three-digit plan	
	ALTH AND WELFARE PLAN				number (PN) ▶	504
					1c Effective date of pl	an
					01/01/1993	
	•	s (employer, if for a single-employer	plan)		2b Employer Identifica	ation
,	ress should include room or s CREDIT UNION	suite no.)			Number (EIN) 91-0333066	
KITOAI	CICEDIT ONION				2c Sponsor's telephor	ne
					number	
P.O. BO	X 990	155 WASH	HINGTON STREET		360-662-2127	
	RTON, WA 98312		TON, WA 98312		2d Business code (see instructions)	
					522130	
		complete filing of this return/repor				
		enalties set forth in the instructions, las the electronic version of this return				
SIGN	Filed with authorized/valid ele	ectronic signature.	07/26/2010	KELLIE LETEXIER		
HERE			_			
	Signature of plan adminis	trator	Date	Enter name of individual s	igning as plan administrator	
SIGN						
HERE						
	Signature of employer/pla	n sponsor	Date	Enter name of individual s	igning as employer or plan sp	onsor
CION						
SIGN						

Signature of DFE Date Enter name
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2009) v.092307.1

Enter name of individual signing as DFE

	Form 5500 (2009) Page <b>2</b>	2		
KE	Plan administrator's name and address (if same as plan sponsor, enter "Same")  LLIE LETEXIER  5 WASHINGTON STREET  EMERTON, WA 98312	3k	91-0 C Adr	ministrator's EIN 0333066 ministrator's telephone mber -662-2127
4 a	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this the plan number from the last return/report:  Sponsor's name	plan, enter the name, EIN an	nd	<b>4b</b> EIN <b>4c</b> PN
5	Total number of participants at the beginning of the plan year		5	277
6	Number of participants as of the end of the plan year (welfare plans complete only lines <b>6a</b> , <b>6b</b> , <b>6</b>	6c, and 6d).	<u> </u>	211
а	Active participants		6a	293
b	Retired or separated participants receiving benefits	,	6b	0
	Other retired or separated participants entitled to future benefits		6c	0
	Subtotal. Add lines <b>6a</b> , <b>6b</b> , and <b>6c</b>		6d	293
				230
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits		6e	
f	Total. Add lines <b>6d</b> and <b>6e</b>		6f	293
g	Number of participants with account balances as of the end of the plan year (only defined contrib complete this item)		6g	
h	Number of participants that terminated employment during the plan year with accrued benefits the less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans		7	
	If the plan provides pension benefits, enter the applicable pension feature codes from the List of lift the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Pla 4A 4B 4D 4E 4H			
9a 10	(1)         X         Insurance         (1)         X           (2)         Code section 412(e)(3) insurance contracts         (2)         (2)           (3)         Trust         (3)         (4)           (4)         General assets of the sponsor         (4)	arrangement (check all that a Insurance Code section 412(e)(3) insu Trust General assets of the spons	uranc	
	Pension Schedules  b General Sch	·	auaci	ileu. (See ilistructions)
u	(1) R (Retirement Plan Information) (1)	H (Financial Informati	ion)	

(2)

(3) (4)

(5)

(6)

I (Financial Information – Small Plan)

**G** (Financial Transaction Schedules)

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

\_\_\_\_\_\_ **A** (Insurance Information)

(2)

(3)

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Co	rporation	<ul> <li>Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</li> </ul>				This Form is Open to Public Inspection	
For calendar plan year 200	09 or fiscal pla	an year beginning 01/01/2009	9	and ending	g 12/31	/2009	
A Name of plan KCU HEALTH AND WEL		B Three-dig plan num	git nber (PN)	<b>&gt;</b>	504		
C Plan sponsor's name a KITSAP CREDIT UNION		D Employer I 91-033306		on Number (	EIN)		
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca VISION SERVICE PLAN	rrier	(d) Contract or	(e) Approximate n	umber of		Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) F	rom	<b>(g)</b> To
91-6056925	47317	12010372			1/01/2009	1	12/31/2009
2 Insurance fee and com- descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3 the	agents, b	rokers, and o	other persons in
(a) Total a	amount of con	nmissions paid		(b) Total a	amount of	fees paid	
3 Persons receiving com	missions and	fees. (Complete as many entrie		persons).			0
	(a) Name	and address of the agent, broke			or fees w	ere paid	
DIMARTINO ASSOCIATE	ES, INC.		11 FIFTH AVENUE, SUITI ATTLE, WA 98101	∃ 3701			
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	549						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commissions	or fees w	ere paid	
	(*)	g	,				
(b) Amount of sales and base		ees and other commission	•				
commissions pa	d	(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500)	2009	Page <b>2-</b> 1			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
	I				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai			
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year en			5	
_		racts 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 corretention of the contract or policy, enter amount	nnection witl	h the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶		ion guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			7d	
		Deductions:				
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	• •			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Page <b>4</b>	

9c(1)(H)

9c(2)

9d(1) 9d(2)

9d(3)

9e

10a

10b

19798

Schedule A (Form 5500) 2009	Page <b>4</b>						
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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.							
8 Benefit and contract type (check all applicable boxes)							
a ☐ Health (other than dental or vision) b ☐ Dental	<b>c</b> ✓ Vision <b>d</b> ☐ Life insurance						
e Temporary disability (accident and sickness) f Long-term disabi	lity <b>g</b> Supplemental unemployment <b>h</b> Prescription drug						
i Stop loss (large deductible) j HMO contract	k ☐ PPO contract I ☐ Indemnity contract						
m ☐ Other (specify) ▶							
9 Experience-rated contracts:							
a Premiums: (1) Amount received	9a(1)						
(2) Increase (decrease) in amount due but unpaid							
(3) Increase (decrease) in unearned premium reserve	9a(3)						
(4) Earned ((1) + (2) - (3))							
<b>b</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)						
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis)							
(A) Commissions							
(B) Administrative service or other fees							
(C) Other specific acquisition costs							
(D) Other expenses							
(E) Taxes							
(F) Charges for risks or other contingencies							
(G) Other retention charges	9c(1)(G)						

(H) Total retention ..... (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) ......

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) ......

Total premiums or subscription charges paid to carrier ...... If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

(2) Claim reserves (3) Other reserves

retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

<sup>12</sup> If the answer to line 11 is "Yes," specify the information not provided.

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation  Insurance companies are required to provide pursuant to ERISA section 103(a)(			a)(2). Inspection				
For calendar plan year 200	09 or fiscal pla	an year beginning 01/01/2009	9	and er	nding 12	/31/2009	
A Name of plan KCU HEALTH AND WELFARE PLAN				B Three plan	e-digit number (P	N) <b>•</b>	504
C Plan sponsor's name a KITSAP CREDIT UNION	s shown on lir	ne 2a of Form 5500.		<b>D</b> Emplo 91-033		cation Number (	EIN)
		ning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:		<u>.</u>		•			
(a) Name of insurance car WASHINGTON DENTAL							
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number		persons covered at end of policy or contract year		From	<b>(g)</b> To
91-0621480	47341	824	2	293 01/01/200		009	12/31/2009
2 Insurance fee and communication descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid			of fees paid				
3 Parsons receiving com	missions and t	2950 fees. (Complete as many entric	es as needed to report all	nercone)			0
• 1 ersons receiving comi		and address of the agent, broke			iona or food	wore poid	
DIMARTINO ASSOCIATE		130	1 FIFTH AVENUE, SUIT ATTLE, WA 98101		ons or rees	s were palu	
(b) Amount of sales an	d boss	F	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code
	2950						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees	were paid	
(b) Amount of sales and base Fees and other comm			ees and other commissio				
commissions pai	d	(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500)	2009	Page <b>2-</b> 1			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
	I				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai			
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year en			5	
_		racts 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 corretention of the contract or policy, enter amount	nnection witl	h the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶		ion guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			7d	
		Deductions:				
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	• •			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Page	4	

X No

Yes

Part III Welfare Benefit Contract Information

		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts w	urposes if such contracts	are experienc	e-rated as a unit. Who	ere contracts		
8	Ben	nefit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> X Dental	С	Vision	C	Life insuran	ce
	е	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Supplemental unemp	oloyment <b>ľ</b>	n Prescription	drug
	i İ	Stop loss (large deductible)	j HMO contract	, s⊟ k∏	PPO contract		I Indemnity c	•
	- L	Other (specify)	, Lime contract	□	11 0 comicor			Jillaot
	m	Other (specify) F						
9	Exp	erience-rated contracts:						
Ŭ	•	Premiums: (1) Amount received		9a(1)		196421		
	_	(2) Increase (decrease) in amount due but unpaid						
		(3) Increase (decrease) in unearned premium res		- (-)				
		(4) Earned ((1) + (2) - (3))				9a(4)		196421
	b	Benefit charges (1) Claims paid		. 9b(1)		141401		
		(2) Increase (decrease) in claim reserves		9b(2)		3000		
		(3) Incurred claims (add (1) and (2))				9b(3)		144401
		(4) Claims charged				9b(4)		144401
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)		2950		
		(B) Administrative service or other fees		9c(1)(B)		31424		
		(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						
		(G) Other retention charges				2 (1) (1)		0.407.4
		(H) Total retention	_	_		9c(1)(H)		34374
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or c	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		8000
		(3) Other reserves				9d(3)		
	е_	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in <b>c(2)</b> .)		9e		
1(	_	onexperience-rated contracts:						
	a	Total premiums or subscription charges paid to c				10a		
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo	, ,		•	10b		
	Sr	pecify nature of costs	orted in r dit i, item 2 abo	ve, report and	Junt	100	I	
	O,	really flatare or costs 7						

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

**Provision of Information** 

Part IV

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation  Insurance companies are required to provide the informati pursuant to ERISA section 103(a)(2).						m is Open to Public Inspection	
For calendar plan year 200	09 or fiscal pla	n year beginning 01/01/2009	9	and er	nding 12	/31/2009	
A Name of plan KCU HEALTH AND WELI	FARE PLAN			<b>B</b> Three plan	e-digit number (Pl	N) <b>•</b>	504
C Plan sponsor's name as shown on line 2a of Form 5500. KITSAP CREDIT UNION				<b>D</b> Emplo 91-033		cation Number (	EIN)
		ning Insurance Contract Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance car GROUP HEALTH COOPE							
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
91-0511770	95672	0292200		66	01/01/20	009	12/31/2009
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in
(a) Total a	amount of com	missions paid		<b>(b)</b> To	tal amount	of fees paid	
2.5		3969					0
Persons receiving com		ees. (Complete as many entrie					
DIMARTINO ASSOCIATE			if, or other person to who 1 FIFTH AVENUE, SUIT ATTLE, WA 98101		ons or rees	s were paid	
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	)		(e) Organization code
	3969						3
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	F	ees and other commissio				
commissions pai	d	(c) Amount		(d) Purpose	9		(e) Organization code

Schedule A (Form 5500)	2009	Page <b>2-</b> 1	
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
	I		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai	
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year en			5	
_		racts 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 corretention of the contract or policy, enter amount	nnection witl	h the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶		ion guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			7d	
		Deductions:				
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	• •			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Page <b>4</b>		

286881

10a

10b

	Schedule A (Form 5500) 2009		F	Page 4		
Part I	Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the surposes if such contracts	are experien	ce-rated as a unit. Wh	nere contrac	
8 Ben	efit and contract type (check all applicable boxes)	)				
а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
е	Temporary disability (accident and sickness)	f Long-term disabilit	ty <b>g</b>	Supplemental unem	ployment	h   Prescription drug
i İ	Stop loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity contract
m	Other (specify)	<i>•</i> ⊔	L	_		_ ,,,,,,,,,,
[	_ culei (epocily)					
<b>9</b> Exp	erience-rated contracts:					
	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpai	d	9a(2)			
	(3) Increase (decrease) in unearned premium re-	serve	9a(3)		T	
_	(4) Earned ((1) + (2) - (3))	i i		I	9a(4)	
b	Benefit charges (1) Claims paid					
	(2) Increase (decrease) in claim reserves		· · · · · ·		01 (0)	
	(3) Incurred claims (add (1) and (2))				9b(3)	
•	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (c) (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		0 (4)(=)			
	(F) Charges for risks or other contingencies.		9c(1)(F)			
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention				9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	e amounts were 🗌 paid in	cash, or	credited.)	- 9c(2)	
d	Status of policyholder reserves at end of year: (	1) Amount held to provide	benefits afte	r retirement	. 9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
<u>e</u>	Dividends or retroactive rate refunds due. (Do n	not include amount entered	d in <b>c(2)</b> .)		9e	
10 No	nevnerience-rated contracts:					

Part IV Provision of Information			
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No	

a Total premiums or subscription charges paid to carrier ...... 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, item 2 above, report amount.....

Specify nature of costs >

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

► Insurance companies are required to provide the pursuant to ERISA section 103(a)(2)				ation	This Fo	rm is Open to Public Inspection
For calendar plan year 20	09 or fiscal plan	year beginning 01/01/2009	and e	ending 12/3	1/2009	
A Name of plan KCU HEALTH AND WEL	FARE PLAN			ee-digit n number (PN)	<b>)</b>	504
C Plan sponsor's name a KITSAP CREDIT UNION		e 2a of Form 5500.		oyer Identificat 33066	tion Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca		COMPANY				
(L) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or o	contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) F	rom	( <b>g</b> ) To
06-0893662	80926	2466646	251	01/01/2009	9	12/31/2009
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in item	3 the agents, b	orokers, and	other persons in
(a) Total amount of commissions paid			(b) ⊤	otal amount of	f fees paid	
	5016					
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all persons).			
		nd address of the agent, broker, c		sions or fees w	vere paid	
DIMARTINO ASSOCIATE		1301 F	IFTH AVENUE, SUITE 3701 LE, WA 98101			
(b) Amount of sales ar	nd hase	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpos	(e) Organization code		
	2508					3
	(a) Name a	nd address of the agent, broker, c	r other person to whom commiss	sions or fees w	vere paid	
THEODORE CHRISTEN	SEN		OX 2046 ERTON, WA 98310			
(b) Amount of sales ar	nd hase	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpos	se		(e) Organization code
	2508					3
Fan Banananah Barbarda	n Ant Notice o	nd OMP Control Numbers coo	the instructions for Form FF00		0-1	adula A (Farm FF00) 2000

Schedule A (Form 5500)	2009	Page <b>2-</b> 1	
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
	I		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai	
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year en			5	
_		racts 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 corretention of the contract or policy, enter amount	nnection witl	h the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶		ion guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			7d	
		Deductions:				
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	• •			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Schedule A (Form 5500) 2009		Page <b>4</b>							
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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.									
and contract type (check all applicable boxes)									
lealth (other than dental or vision)	<b>b</b> Dental	<b>c</b> Vision	<b>d</b> X Life insurance						
emporary disability (accident and sickness)	f X Long-term disability	<b>g</b> Supplemental unemployment	<b>h</b> Prescription drug						
Stop loss (large deductible) Other (specify) ACCIDENTAL DEATH AND	j HMO contract	<b>k</b> ☐ PPO contract	I Indemnity contract						

8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	c 🗌	Vision		<b>d</b> X Life insurance	
	е	Temporary disability (accident and sickness)	f X Long-term disability	g	Supplemental unemp	loyment	h Prescription drug	
	i Î	Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract	
	m						- L	
	L	(-)						
9	Ехре	erience-rated contracts:	_					
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	d	9a(2)				
		(3) Increase (decrease) in unearned premium res	erve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes	l l	9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges	_	9c(1)(G)				
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were naid in o	eash, or $\Box$	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1	_	L-1		9d(1)		
	٠.	. ,	'			9d(2)		
		(2) Claim reserves						
	6	Dividends or retroactive rate refunds due. (Do no				9d(3) 9e		
10		nexperience-rated contracts:	or morade amount entered i	<u>\(_j.</u> )		36		
	a	Total premiums or subscription charges paid to c	arrier			10a	49	9574
	b	If the carrier, service, or other organization incurr				100		
		retention of the contract or policy, other than repo				10b		
	Sp	ecify nature of costs		·				

Part IV	Provision of Information			
<b>11</b> Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

Part III

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation  Insurance companies are required to propursuant to ERISA section 103				nation		m is Open to Public Inspection	
For calendar plan year 200	09 or fiscal plan	year beginning 01/01/2009	and	ending 12	2/31/2009		
A Name of plan KCU HEALTH AND WELI	FARE PLAN			ree-digit an number (P	N) <b>•</b>	504	
C Plan sponsor's name a KITSAP CREDIT UNION	s shown on line	2a of Form 5500.		D Employer Identification Number (EIN) 91-0333066			
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance car KPS HEALTH PLANS	rrier	(d) Contract or	(e) Approximate number of		Policy or co	ontract year	
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year	(f)	From	<b>(g)</b> To	
91-0540525	53872	22751	210	01/01/20	009	12/31/2009	
2 Insurance fee and communication descending order of the		tion. Enter the total fees and tota	ll commissions paid. List in iter	n 3 the agents	, brokers, and c	ther persons in	
(a) Total a	amount of comm		(b)	Total amount	of fees paid		
3 Persons receiving com	missions and fe	as (Complete as many entries a	as needed to report all persons			0	
U I CISONS ICCCIVING COM		nd address of the agent, broker,			were paid		
DIMARTINO ASSOCIATE		1301 F	FIFTH AVENUE, SUITE 3701 TLE, WA 98101	3310113 01 1000	s were paid		
(b) Amount of sales ar	nd hase	Fees	s and other commissions paid				
commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
36185						3	
	(a) Name a	nd address of the agent, broker,	or other person to whom comm	ssions or fees	were paid		
(b) Amount of sales and base			s and other commissions paid				
commissions pai		(c) Amount	<b>(d)</b> Purp	ose		(e) Organization code	
	n And Nation	nd OMP Control Numbers 2000	the instructions for Fore Fig.	20	2:	odulo A /Form 5500) 2000	

Schedule A (Form 5500)	2009	Page <b>2-</b> 1				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d			
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d			
	I					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai				
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each this report.		cts with each carrier may	be treated	d as a unit for purposes of		
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year en			5	
_		racts 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 corretention of the contract or policy, enter amount	nnection witl	h the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶		ion guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			7d	
		Deductions:				
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	• •			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

	Schedule A (Form 5500) 2009		F	Page <b>4</b>			
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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.							
8 Bene	fit and contract type (check all applicable boxes)						
a >	Health (other than dental or vision)	<b>b</b> Dental	С	Vision	d	Life insurance	
e [	Temporary disability (accident and sickness)	f Long-term disabili	tv <b>a</b> [	∃ Supplemental unemp	olovment <b>h</b>	Prescription drug	
: [	Stop loss (large deductible)	i HMO contract		PPO contract			
'	, , , ,	I HIMO contract	ΥĽ	PPO contract	'	Indemnity contract	
m [	Other (specify)						
0 -							
	rience-rated contracts:		0. (4)	1			
	Premiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpai		9a(2)				
	(3) Increase (decrease) in unearned premium re				05(4)		
-	(4) Earned ((1) + (2) - (3))				9a(4)		
	Benefit charges (1) Claims paid						
	(2) Increase (decrease) in claim reserves		· · · · · ·		01-(0)		
	(3) Incurred claims (add (1) and (2))				9b(3)		
	(4) Claims charged				9b(4)		
С	Remainder of premium: (1) Retention charges (		0=/4\/A\	<u> </u>			
	(A) Commissions		9c(1)(A)				
	(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)				
	(C) Other specific acquisition costs		9c(1)(D)				
	(D) Other expenses		- (1)(=)				
	(E) Charges for risks as other continuous		0 (4)(=)				
	(F) Other retestion shares		- ////->				
	(G) Other retention charges				0c(1)(H)		
	(A) Divided the constant of th	_	_		9c(1)(H)		
	(2) Dividends or retroactive rate refunds. (These						
d	Status of policyholder reserves at end of year: (	•			9d(1)		
	(2) Claim reserves				9d(2)		

9d(3)

9e

10a

10b

1206170

(3) Other reserves

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

a Total premiums or subscription charges paid to carrier ......

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, item 2 above, report amount.....

Specify	nature	٥f	costs	
Opedity	Hatuie	OI	COSIS	•

10 Nonexperience-rated contracts:

Part IV	Provision of Information			
<b>11</b> Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Service Provider Information**

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2009

This Form is Open to Public Inspection.

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009	and ending 12/31/2009			
A Name of plan	<b>B</b> Three-digit			
KCU HEALTH AND WELFARE PLAN	plan number (PN) 504			
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)			
KITSAP CREDIT UNION	91-0333066			
	01 000000			
Part I Service Provider Information (see instructions)				
You must complete this Part, in accordance with the instructions, to report the inform or more in total compensation (i.e., money or anything else of monetary value) in coplan during the plan year. If a person received <b>only</b> eligible indirect compensation f answer line 1 but are not required to include that person when completing the remainstructure.	onnection with services rendered to the plan or the person's position with the for which the plan received the required disclosures, you are required to			
1 Information on Persons Receiving Only Eligible Indirect Comp	pensation			
a Check "Yes" or "No" to indicate whether you are excluding a person from the remain				
indirect compensation for which the plan received the required disclosures (see insti	ructions for definitions and conditions)			
<b>b</b> If you answered line 1a "Yes," enter the name and EIN or address of each person preceived only eligible indirect compensation. Complete as many entries as needed				
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation			
(b) Established Elli) and delegate of a second position	described and the second of th			
(b) Enter name and EIN or address of person who provided	a you disclosure on eligible indirect compensation			
(b) Enter name and EIN or address of person who provided	I you disclosures on eligible indirect compensation			
(b) Enter name and EIN or address of narrow who are sided	A your disclosures on cligible indirect compensation			
(b) Enter name and EIN or address of person who provided	r you disclosures on eligible indirect compensation			

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(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	l "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 to	otal compensation
			(a) Enter name and EIN or	address (see instructions)		
			- <b>,</b>			
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
(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?
			Yes No	Yes No		Yes No

Page <b>4-</b> 1	Page	4-	1
------------------	------	----	---

		(	a) Enter name and EIN or	address (see instructions)			
(b)	(c)	(d)	(e)	(f)	(g)	(h)	
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect	Did indirect compensation include eligible indirect	Enter total indirect compensation received by	Did the service provider give you a	
	organization, or person known to be	by the plan. If none, enter -0	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or	
	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element	estimated amount?	
					(f). If none, enter -0		
			Yes No	Yes No		Yes 📗 No 📗	
		(	a) Enter name and EIN or	address (see instructions)			
(b)	(c)	(d)	(e)	(f)	(g)	(h)	
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect	Did indirect compensation include eligible indirect	Enter total indirect compensation received by	Did the service provider give you a	
( )		by the plan. If none, enter -0	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or	
	a party-in-interest	Citici o .	sponsor)	disclosures?	compensation for which you answered "Yes" to element		
					(f). If none, enter -0		
			Yes No	Yes No		Yes   No	
			->-				
		(	a) Enter name and EIN or	address (see instructions)			
(b)	(c)	(d)	(e)	(f)	(g)	(h)	
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect	Did indirect compensation include eligible indirect	Enter total indirect compensation received by	Did the service provider give you a	
, ,	organization, or person known to be	by the plan. If none, enter -0	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or	
	a party-in-interest	0.1.01	sponsor)	disclosures?	compensation for which you answered "Yes" to element		
					(f). If none, enter -0		
			Yes   No	Yes No		Yes   No	

Schedule	C	(Form	5500)	2009
Ochicadic	$\sim$	(1 01111	3300	, 2000

Page <b>5-</b>	1
----------------	---

## Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

many entities as needed to report the required information for each source.		
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect of	compensation, including any
	formula used to determine	the service provider's eligibility he indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he indirect compensation.

Page <b>6-</b>	1
----------------	---

Part II Service Providers Who Fail or Refuse to Provide Information				
Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.				
(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		

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)		
а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	<b>e</b> Telephone:
Ex	xplanation:	
а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	e Telephone:
Ex	xplanation:	
а	Name:	<b>b</b> EIN:
C	Position:	D LIN.
d	Address:	e Telephone:
Ex	xplanation:	
а	Name:	<b>b</b> EIN;
C	Position:	₩ ±111,
d	Address:	e Telephone:
-		
Ex	xplanation:	
а	Name:	<b>b</b> EIN;
C	Position:	
d	Address:	e Telephone:
Ex	xplanation:	