Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089		
Department of the Treasury Internal Revenue Service 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).				
Department of Labor Employee Benefits Security Administration	 Complete all entries in accordance with the instructions to the Form 5500. 	2009		
Pension Benefit Guaranty Corporation		This Form is Open to Public Inspection		
Part I Annual Report Ider	tification Information			
For calendar plan year 2009 or fiscal	plan year beginning 01/01/2009 and ending 12/31/2	2009		
A This return/report is for:	a multiemployer plan; a multiple-employer plan; or			
·	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 t	han 12 months).		
C If the plan is a collectively-bargain	ed plan, check here.			
D Check box if filing under:	Form 5558; automatic extension;	the DFVC program;		
	special extension (enter description)			
Part II Basic Plan Inform	nation—enter all requested information			
1a Name of plan WHIDBEY ISLAND BANK HEALTH 8	·	1b Three-digit plan number (PN) ▶ 501		
		1c Effective date of plan 01/01/1961		
2a Plan sponsor's name and addres (Address should include room or s WHIDBEY ISLAND BANK	s (employer, if for a single-employer plan) suite no.)	2b Employer Identification Number (EIN) 91-0726237		
		2c Sponsor's telephone number 360-679-3121		
PO BOX 7001 OAK HARBOR, WA 98277	450 SW BAYSHORE DRIVE OAK HARBOR, WA 98277	2d Business code (see instructions) 522110		

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	Filed with authorized/valid electronic signature.	07/28/2010	LYNN GARRISON
HERE		Date	Enter name of individual signing as plan administrator
SIGN	Filed with authorized/valid electronic signature.	07/28/2010	LYNN GARRISON
HERE		Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

	a Plan administrator's name and address (if same as plan sponsor, enter "Same") WHIDBEY ISLAND BANK		3b Administrator's EIN 91-0726237		
PO			3C Administrator's telephone number 360-679-3121		
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN the plan number from the last return/report:	N and	4b EIN		
а	Sponsor's name		4c PN		
5	Total number of participants at the beginning of the plan year	5	263		
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).				
а	Active participants	. 6a	294		
b	Retired or separated participants receiving benefits	. 6b	0		
с	Other retired or separated participants entitled to future benefits	. 6c	0		
d	Subtotal. Add lines 6a, 6b, and 6c	. 6d	294		
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	. 6e			
f	Total. Add lines 6d and 6e	. 6f			
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g			
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.	6h			
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	. 7			

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: 4A 4B 4D 4E 4H

9a	9a Plan funding arrangement (check all that apply)				9b Plan benefit arrangement (check all that apply)			
	(1)	X	Insurance	(1)		X	Insurance	
	(2)		Code section 412(e)(3) insurance contracts	(2)			Code section 412(e)(3) insurance contracts	
	(3)		Trust	(3)			Trust	
	(4)	×	General assets of the sponsor	(4)		X	General assets of the sponsor	
10	Check	all ap	plicable boxes in 10a and 10b to indicate which schedules are a	ttached, a	and, wh	ere	indicated, enter the number attached. (See instructions)	
a Pension Schedules					b General Schedules			
а	Pensio	n Sc	hedules	b G	eneral S	Sch	edules	
а	Pensio (1)	n Sci	hedules R (Retirement Plan Information)	b G (1		Sch	edules H (Financial Information)	
а		n Sc				Sch		
а	(1)	n Sci	 R (Retirement Plan Information) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan 	(1		Sch X	H (Financial Information)	
a	(1)	n Sc	R (Retirement Plan Information)MB (Multiemployer Defined Benefit Plan and Certain Money	(1 (2		Sch X	H (Financial Information)I (Financial Information – Small Plan)	
а	(1)	n Sc	 R (Retirement Plan Information) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan 	(1 (2 (3		Sch X	 H (Financial Information) I (Financial Information – Small Plan) 4 (Insurance Information) 	

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SCHEDULE	A	Insuranc	e Informatio	า				
(Form 5500))					0	OMB No. 1210-0110	
Department of the Treas Internal Revenue Serv		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2009	
Department of Labo Employee Benefits Security Ad		▶ File as an attachment to Form 5500.						
Pension Benefit Guaranty Co	orporation	 Insurance companies ar pursuant to EF 	e required to provide to RISA section 103(a)(2)		ion	This Fo	orm is Open to Public Inspection	
For calendar plan year 20	09 or fiscal plar	year beginning 01/01/2009		and er	nding 12	/31/2009	•	
A Name of plan WHIDBEY ISLAND BANK	K HEALTH & W	ELFARE PLAN			e-digit number (Pl	N) 🕨	501	
C Plan sponsor's name a WHIDBEY ISLAND BANK		e 2a of Form 5500.		D Emplo 91-072	-	ation Number	r (EIN)	
on a separat 1 Coverage Information: (a) Name of insurance ca	te Schedule A.	ing Insurance Contract C Individual contracts grouped as a						
PREMERA BLUE CROS	S							
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a policy or contrac	t end of	(f)	Policy or o	contract year (g) To	
91-0499247	47570	1032615)9	01/01/20	009	12/31/2009	
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	l commissions paid. Li	ist in item 3	the agents	, brokers, and	other persons in	
0	amount of comr	•		(b) To	otal amount	of fees paid		
		0					4392	
3 Persons receiving com		ees. (Complete as many entries a						
		nd address of the agent, broker, c	or other person to whor X 84581	m commiss	ions or fees	were paid		
WELLS FARGO INSURA	INCE SERVICE		FLE, WA 98124					
(b) Amount of sales ar	nd base	Fees	and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpos			(e) Organization code	
		4392 PRI	EFERRED PRODUCE	R PROGR	AM		3	
	(a) Name a	nd address of the agent, broker, c	or other person to who	m commise	ions or feas	were naid		
(b) Amount of color of	ad base	Fees	and other commission	ns paid				
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose				(e) Organization code				

	see the instructions for Form 5500

Schedule A (Form 5500) 2009 v.092308.1

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Na	me and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	

(b) Amount of sales and base		Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6		acts With Allocated Funds:				
	а	State the basis of premium rates				
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			6d	
		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		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d 1	Fotal of balance and additions (add b and c(6))				
	e [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				
		Balance at the end of the current year (subtract e(5) from d)			7 f	

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Pa	art III	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr	oup of employees of the s	same employ	er(s) or members of th	ne same em	ployee organization(s), the
		information may be combined for reporting put the entire group of such individual contracts					ts cover individual employees,
8	Bene	fit and contract type (check all applicable boxes)	,				
	a 🛛	1	b Dental	c	Vision		d Life insurance
	еГ	Temporary disability (accident and sickness)	f Long-term disabilit		1	nlovmont	h Prescription drug
						pioyment	
		Stop loss (large deductible)	j HMO contract	k ×	PPO contract		I Indemnity contract
	m	Other (specify)					
9		rience-rated contracts:					_
		remiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpaid					_
		(3) Increase (decrease) in unearned premium res		9a(3)			
	-	(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 (o		0-(4)(4)			-
		(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)			-1
		(D) Other expenses (E) Taxes		9c(1)(E)			-
		(F) Charges for risks or other contingencies.					-
		(G) Other retention charges		9c(1)(G)			-
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	_	_			
		Status of policyholder reserves at end of year: (1					
		(2) Claim reserves				9d(1)	
		(3) Other reserves				9d(3)	
		Dividends or retroactive rate refunds due. (Do no				9e	
10		nexperience-rated contracts:		•••••••••••••••••••••••••••••••••••••••			
		Total premiums or subscription charges paid to c	arrier			. 10a	1653315
	-	If the carrier, service, or other organization incur					
		retention of the contract or policy, other than repo				. 10b	

Specify nature of costs

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

SCHEDULE	Α	Insuran	ce Informatio	n			1D No. 1010 0110
(Form 5500)				ON	/IB No. 1210-0110		
Department of the Treasury Internal Revenue ServiceThis schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2009			
Department of Labo Employee Benefits Security Ad		File as an a	attachment to Form 55	00.			
Pension Benefit Guaranty Co	orporation	Insurance companies a pursuant to E	are required to provide t ERISA section 103(a)(2)		ion	This For	rm is Open to Public Inspection
For calendar plan year 20	09 or fiscal plan	•	() ()	and e	nding 12	/31/2009	Inspection
A Name of plan WHIDBEY ISLAND BANK	K HEALTH & W	ELFARE PLAN			e-digit number (Pl	N) 🕨	501
C Plan sponsor's name a WHIDBEY ISLAND BANK		e 2a of Form 5500.		D Emplo 91-072	-	ation Number	(EIN)
		ing Insurance Contract (Individual contracts grouped as					
1 Coverage Information:		ž :		•			
(a) Name of insurance ca	rrior						
PRUDENTIAL INSURAN		OF AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac	(t) From		From	(g) To
22-1211670	68241	02346	29	94	01/01/2009		12/31/2009
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and o	other persons in
(a) Total a	amount of comr	•		(b) To	otal amount	of fees paid	
		0					8
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,			ions or fees	were paid	
AXA ASSISTANCE, USA		SUITE	OUTH MICHIGAN AVE E 1100 AGO, IL 60603-6115	INUE			
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			
commissions paid		(c) Amount		· · · · · · · · · · · · · · · · · · ·			(e) Organization code
	HIRD PARTY ADMINISTRATION FEES		5				
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
						·	
		Fee	and other commission	ns naid			

(b) Amount of sales and base	F	1		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
For Paperwork Reduction Act Notice	edule A (Form 5500) 2009			
-			v.092308.1	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	

(b) Amount of sales and base		(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 indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er	5			
6		acts With Allocated Funds:				
	а	State the basis of premium rates				
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			6d	
		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		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d 1	Fotal of balance and additions (add b and c(6))				
	e [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				
		Balance at the end of the current year (subtract e(5) from d)			7 f	

Pa	rt II	I Welfare Benefit Contract Information If more than one contract covers the same group of information may be combined for reporting purpose the entire group of such individual contracts with ea	es if such contracts a	re experiend	ce-rated as a unit. Wh	ere contract	
8	Ben	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision) b	Dental	c	Vision		d 🛛 Life insurance
	e	Temporary disability (accident and sickness) f	Long-term disability	⁄ g	Supplemental unem	ployment	h Prescription drug
	ίĪ	Stop loss (large deductible)	HMO contract	k [PPO contract		I Indemnity contract
	m	Other (specify) ACCIDENTAL DEATH & DISMEN		L	1		
9	Expe	erience-rated contracts:					
	•	Premiums: (1) Amount received		9a(1)			1
		(2) Increase (decrease) in amount due but unpaid		9a(2)			7
		(3) Increase (decrease) in unearned premium reserve.		9a(3)			7
		(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 (on an a	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		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)		T	
		(H) Total retention				9c(1)(H)	,
		(2) Dividends or retroactive rate refunds. (These amount	unts were paid in o	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amo	ount held to provide b	enefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not incl	ude amount entered	in c(2) .)		9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carrier				10a	10877
	b	If the carrier, service, or other organization incurred an retention of the contract or policy, other than reported in				. 10b	
	Sp	ecify nature of costs 🕨					

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

SCHEDULE		Insuranc	e Information		0	MB No. 1210-0110	
(Form 5500) Department of the Treasur		This schedule is required	to be filed under section 10	4 of the			
Internal Revenue Service Employee Retirement Income Security Act of 1974 (ERISA). Department of Labor Employee Retirement Income Security Act of 1974 (ERISA).					2009		
Employee Benefits Security Admi		File as an at	ttachment to Form 5500.				
Pension Benefit Guaranty Corp	poration		re required to provide the in RISA section 103(a)(2).			orm is Open to Public Inspection	
or calendar plan year 2009 Name of plan	9 or fiscal plan	year beginning 01/01/2009	_	9	/31/2009		
VHIDBEY ISLAND BANK	HEALTH & W	ELFARE PLAN	В	Three-digit plan number (Pl	N) 🕨	501	
Plan sponsor's name as WHIDBEY ISLAND BANK	shown on line	2a of Form 5500.		Employer Identific 91-0726237	ation Numbe	r (EIN)	
		ing Insurance Contract C Individual contracts grouped as a					
Coverage Information:							
a) Name of insurance carr	ier						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number persons covered at end		Policy or	contract year	
	code	identification number	policy or contract yea	(†)	From	(g) To	
1-6056925	47317	12284977	226	01/01/20	09	12/31/2009	
Insurance fee and comm descending order of the a		tion. Enter the total fees and tota	I commissions paid. List in	item 3 the agents	, brokers, and	l other persons in	
ů.	mount of comm			(b) Total amount	of fees paid		
		1394					
Persons receiving comm		es. (Complete as many entries a		,			
AON CONSULTING, INC.	(a) Name al	nd address of the agent, broker, o PO BC CHAR	DX 905494 LOTTE, NC 28290-5494	mmissions of fees	were paid		
(b) Amount of sales and	l base	Fees	s and other commissions pa	aid		_	
commissions paid	1189	(c) Amount	(d) F	Purpose		(e) Organization code	
	1109					5	
	(a) Name a	nd address of the agent, broker, o	or other person to whom co	mmissions or fees	were paid		
WELLS FARGO INSURAN	CE SERVICE	PO BC	HWEST - SEATTLE LOCKI X 84581 FLE, WA 98124-5881	BOX			
(b) Amount of sales and		Fees	s and other commissions pa	aid			
commissions paid		(c) Amount	(d) F	Purpose		(e) Organization code	
	205					3	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid		

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(b) Amount of sales and base		(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 indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er	5			
6		acts With Allocated Funds:				
	а	State the basis of premium rates				
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			6d	
		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		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	d 1	Fotal of balance and additions (add b and c(6))				
	e [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				
		Balance at the end of the current year (subtract e(5) from d)			7 f	

Pag	e	4	

Pa	art III	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting por the entire group of such individual contracts	urposes if such contracts	are experienc	e-rated as a unit. Wh	ere contract	
8	Bene	fit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	с×	Vision		d Life insurance
	еГ	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unem	olovment	h Prescription drug
	ιΓ	Stop loss (large deductible)	i HMO contract	י, ש∟ k	PPO contract		I Indemnity contract
				n_			
	m	Other (specify)					
9	Evno	rience-rated contracts:					
J	•	Premiums: (1) Amount received		9a(1)			-
		(2) Increase (decrease) in amount due but unpaid					
		(3) Increase (decrease) in unearned premium res					1
		(4) Earned ((1) + (2) - (3))				9a(4)	
	-	Benefit charges (1) Claims paid				1 1 1 1	
		(2) Increase (decrease) in claim reserves					7
		(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					_
		(F) Charges for risks or other contingencies.					_
		(G) Other retention charges					
		(H) Total retention	_	_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)	
		Status of policyholder reserves at end of year: (1	, 1				
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
		Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in c(2) .)		9e	
10		nexperience-rated contracts:					00044
	-	Total premiums or subscription charges paid to c				10a	29911
		If the carrier, service, or other organization incur retention of the contract or policy, other than rep				10b	
		recontion of the contract of policy, other than rep	JICO III I AILI, IICIII Z ADU	ve, report ann	ount	1 100	

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
40				

						1	
SCHEDULE	Α	Insurance Information				OMB No. 1210-0110	
(Form 5500)						
Department of the Treas Internal Revenue Serv		This schedule is required Employee Retirement Ind					2009
Department of Labor Employee Benefits Security Ad		File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty Co		Insurance companies a	are required to provide t	he informa	ion	This For	m is Open to Public
		1	RISA section 103(a)(2)				Inspection
For calendar plan year 200	09 or fiscal plan	year beginning 01/01/2009		and e	- 5	2/31/2009	
A Name of plan WHIDBEY ISLAND BANK	KHEALTH & W	ELFARE PLAN			e-digit number (P	N)	501
				plai	number (i	(1)	
C Plan sponsor's name a	is shown on line	2a of Form 5500			ver Identifi	cation Number ((FIN)
WHIDBEY ISLAND BANK		, za or i onn 3300.		91-072	-		
		ing Insurance Contract (Individual contracts grouped as					
1 Coverage Information:				•		0	
(a) Name of insurance ca	**:0 *						
UNION SECURITY INSU							
			1		r		
(b) EIN (c) NAIO code		(d) Contract or	(e) Approximate nu persons covered a			,	ontract year
		identification number	policy or contrac		(f)	From	(g) To
81-0170040	70408	0408 G4045673 287 01/01/2009 12		12/31/2009			
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and o	other persons in
	amount of comn	nissions paid		(b) To	otal amount	of fees paid	
		465					0
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,		m commiss	ions or fees	s were paid	
WELLS FARGO INSURA			OX 84522 TLE, WA 98124				
(b) Amount of sales ar			ees and other commissions paid			-	
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
	465	0					3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid	
	(
			a and other commission				
(b) Amount of sales ar commissions pai		(c) Amount	es and other commission	ns paid (d) Purpos	e		(e) Organization code

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid					
commissions paid		code				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		

(b) Amount of sales and base		(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 indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of			
		this report.			, 				
-		ent value of plan's interest under this contract in the general account at year of							
-		Irrent value of plan's interest under this contract in separate accounts at year end							
6		Contracts With Allocated Funds:							
	а	State the basis of premium rates							
	h				Ch				
		Premiums paid to carrier			6b 6c				
		Premiums due but unpaid at the end of the year							
		retention of the contract or policy, enter amount			6d				
		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		acts With Unallocated Funds (Do not include portions of these contracts mai	• •						
				ition guarantee					
		(3) ☐ guaranteed investment (4) ☐ other ►		C C					
	b	Balance at the end of the previous year							
		Additions: (1) Contributions deposited during the year							
		(2) Dividends and credits	= (0)						
		(3) Interest credited during the year							
		(4) Transferred from separate account							
		(5) Other (specify below)							
		(6)Total additions			7c(6)				
	d 1	Fotal of balance and additions (add b and c(6))							
	e [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							
		Balance at the end of the current year (subtract e(5) from d)			7 f				

Page 4

Pa	art II	Welfare Benefit Contract Informat 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 urposes if such contracts	are experience	ce-rated as a unit. Wh	nere contrac	
8	Bene	afit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance
	e	Temporary disability (accident and sickness)	f 🛛 Long-term disabili	ity g	Supplemental unem	ployment	h Prescription drug
	iΓ	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify) ACCIDENTAL DEATH & DI		Ŀ			
9	Expe	rience-rated contracts:					
	a F	Premiums: (1) Amount received		. 9a(1)			
		(2) Increase (decrease) in amount due but unpai	d	. 9a(2)			
		(3) Increase (decrease) in unearned premium res	serve	. 9a(3)			
		(4) Earned ((1) + (2) - (3))				. 9a(4)	
		Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves		. 9b(2)		T	
	(3) Incurred claims (add (1) and (2))					. 9b(3)	
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (c	on an accrual basis)	r			
		(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.					
		(G) Other retention charges		9c(1)(G)		1	
		(H) Total retention	······ <u>-</u> ·····	·····		. 9c(1)(H))
		(2) Dividends or retroactive rate refunds. (These	e amounts were paid ir	n cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1	I) Amount held to provide	benefits after	retirement	. 9d(1)	
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves				. 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in c(2) .)		. 9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to a	carrier			. 10a	96210
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep				. 10b	

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
40				

(Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation For calendar plan year 2009 or fiscal plan year A Name of plan WHIDBEY ISLAND BANK HEALTH & WEL C Plan sponsor's name as shown on line 2 WHIDBEY ISLAND BANK Part I Service Provider Inform You must complete this Part, in accordar	FARE PLAN a of Form 5500	ity Act of 1974 (ERISA). nent to Form 5500. and ending 12/31 B Three-digit plan number (PN)	//2009	2009 Form is Open to Public Inspection.			
Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation For calendar plan year 2009 or fiscal plan year A Name of plan WHIDBEY ISLAND BANK HEALTH & WEL C Plan sponsor's name as shown on line 2 WHIDBEY ISLAND BANK Part I Service Provider Inform	Retirement Income Securit File as an attachme ear beginning 01/01/2009 FARE PLAN a of Form 5500	ity Act of 1974 (ERISA). nent to Form 5500. B Three-digit plan number (PN) D Employer Identificat	//2009	Form is Open to Public Inspection.			
Employee Benefits Security Administration Pension Benefit Guaranty Corporation For calendar plan year 2009 or fiscal plan year A Name of plan WHIDBEY ISLAND BANK HEALTH & WEL C Plan sponsor's name as shown on line 2 WHIDBEY ISLAND BANK Part I Service Provider Inform	ear beginning 01/01/2009 FARE PLAN a of Form 5500	and ending 12/31 B Three-digit plan number (PN) D Employer Identificat	//2009	Inspection.			
For calendar plan year 2009 or fiscal plan year A Name of plan WHIDBEY ISLAND BANK HEALTH & WEL C Plan sponsor's name as shown on line 2 WHIDBEY ISLAND BANK Part I Service Provider Inform	FARE PLAN a of Form 5500	B Three-digit plan number (PN) D Employer Identificat	•	501			
A Name of plan WHIDBEY ISLAND BANK HEALTH & WEL C Plan sponsor's name as shown on line 2 WHIDBEY ISLAND BANK Part I Service Provider Inform	FARE PLAN a of Form 5500	B Three-digit plan number (PN) D Employer Identificat	ion Number				
WHIDBEY ISLAND BANK Part I Service Provider Inform			ion Number	(EIN)			
	ation (see instructions)			1 -			
You must complete this Part, in accordar							
 or more in total compensation (i.e., more plan during the plan year. If a person recanswer line 1 but are not required to inclu 1 Information on Persons Receive a Check "Yes" or "No" to indicate whether y indirect compensation for which the plan b If you answered line 1a "Yes," enter the 	ving Only Eligible indirect compensational terms of the person when completing the revealed that person when completing the revealed the required disclosures (see	tion for which the plan received the req remainder of this Part. ompensation emainder of this Part because they rece e instructions for definitions and condition	uired disclos	gible			
received only eligible indirect compensati		eded (see instructions). vided you disclosures on eligible indired	ct compensa	tion			
(b) Enter name	and EIN or address of person who pro	wided you disclosure on eligible indirec	t compensat	ion			
(b) Enter name a	and EIN or address of person who prov	vided you disclosures on eligible indired	t compensa	tion			
(b) Enter name a	and EIN or address of person who prov	vided you disclosures on eligible indired	t compensa	tion			

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500

(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

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(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

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

		(a) Enter name and EIN or	address (see instructions)			
AON CONS	SULTING		1420 5TH SEATTLI	HAVENUE, SUITE 1200 E, WA 98101			
22-2232264	4						
(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?	
16 22 53 70	CONSULTANT	25746	Yes 🗌 No X	Yes 🗌 No 🗌		Yes 🗌 No 🗌	
		(a) Enter name and EIN or	address (see instructions)			
ASSURAN	T EMPLOYEE BENEF	TT INSURANCE		AND BOULEVARD CITY, MO 64108-2670			
81-0170040	1						
					Γ	Γ	
(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?	
12	CLAIMS ADMINISTRATOR	10437	Yes 🗌 No 🛛	Yes 🗌 No 🗌		Yes 🗌 No 🗍	
		(a) Enter name and EIN or	address (see instructions)			
BENEFIT COORDINATORS CORPORATION100 RYAN COURT, SUITE 200 PITTSBURGH, PA 15205-1324							
25-1453488	3						
(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?	
12	CLAIMS ADMINISTRATOR	5262	Yes 🗌 No 🛛	Yes 🗌 No 🗌		Yes 🗌 No 🗌	

(a) Enter name and EIN or address (see instructions)						
		(N		(4)		(1)
(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?
			Yes No	Yes No		Yes 🗌 No 🗌
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(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 🗍
(a) Enter name and EIN or address (see instructions)						
(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?
			Yes No	Yes 🗌 No 🗍		Yes No

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.

(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
	for or the amount of the	he 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	(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	(C) Enter amount of indirect
	(see instructions)	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.

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Part II Service Providers Who Fail or Refuse to	Provide Inform	mation
4 Provide, to the extent possible, the following information for ea this Schedule.	ach service provide	er 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	7-	1
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Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)		
a Name:	b EIN:	
C Position:		
d Address:	e Telephone:	
Explanation:		
a Name:	b EIN:	
C Position: d Address:	e Telephone:	
a Address.	e relepione.	
Explanation:		
a Name:	b EIN:	
C Position:		
d Address:	e Telephone:	
Furlesstice		
Explanation:		
a Name:	b EIN;	
C Position:		
d Address:	e Telephone:	
Explanation:		

а	Name:	b EIN;
С	Position:	
d	Address:	e Telephone:

Explanation: