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 Public Inspection
Part I	Annual Report Iden	tification Information			•
For cale	ndar plan year 2009 or fiscal p			and ending 12/31/2	2009
A This	return/report is for:	a multiemployer plan;	a multiple	e-employer plan; or	
		X a single-employer plan;	a DFE (s	pecify)	
B This	return/report is:	the first return/report;		eturn/report;	
		an amended return/report;	a short pl	an year return/report (less t	han 12 months).
C If the	plan is a collectively-bargaine	ed plan, check here			
D Chec	k box if filing under:	X Form 5558;	automatio	extension;	the DFVC program;
		special extension (enter des	cription)		
Part	II Basic Plan Inform	nation—enter all requested informa	ation		
	ne of plan				1b Three-digit plan
SPEEDY	Y AUTO GLASS HEALTH INS	URANCE TRANS AMERICA GLASS	S, INC WELFARE BE	ENEFITS PLAN	number (PN) ▶ 501 1c Effective date of plan
					03/25/1985
	•	(employer, if for a single-employer)	plan)		2b Employer Identification
`	ress should include room or s	uite no.)			Number (EIN) 91-1255564
WASHIN	NGTON GLASS, INC				2c Sponsor's telephone
					number
9655 SE	36TH ST SUITE 103	9655 SE 3	B6TH ST SUITE 103		800-638-8244
MERCE	R ISLAND, WA 98040-3732	MERCER	ISLAND, WA 98040	-3732	2d Business code (see instructions)
					327210
Caution	: A penalty for the late or in	complete filing of this return/repor	rt will be assessed	unless reasonable cause i	s established.
		enalties set forth in the instructions,			
statemer	nts and attachments, as well a	as the electronic version of this return	n/report, and to the b	est of my knowledge and be	lief, it is true, correct, and complete.
CION	Filed with authorized/valid ele	actronic signature	10/08/2010	SANDY STERNOD	
SIGN HERE Filed with authorized/valid electronic signature. 10/08/2010 SANDY STERNO 10/08/2010		SANDY STERNOD			
	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 sponsor
SIGN					
HEDE					

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 (2000)	Page 2		
WA 965	Form 5500 (2009) Plan administrator's name and address (if same as plan sponsor, enter "Same SHINGTON GLASS, INC 55 SE 36TH ST SUITE 103 RCER ISLAND, WA 98040-3732	Page 2	91- 3c Ad	Iministrator's EIN 1255564 ministrator's telephone mber 0-638-8244
4 a	If the name and/or EIN of the plan sponsor has changed since the last return/rethe plan number from the last return/report: Sponsor's name	report filed for this plan, enter the name, Ell	N and	4b EIN 4c PN
5	Total number of participants at the beginning of the plan year		5	166
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	150
b	Retired or separated participants receiving benefits		6b	2
С	Other retired or separated participants entitled to future benefits		6c	
d	Subtotal. Add lines 6a , 6b , and 6c		6d	152
е	Deceased participants whose beneficiaries are receiving or are entitled to receiving	eive 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 (complete this item)		6g	
h	Number of participants that terminated employment during the plan year with less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only r	multiemployer plans complete this item)	7	
	If the plan provides pension benefits, enter the applicable pension feature code the plan provides welfare benefits, enter the applicable welfare feature codes 4A 4B 4D 4H 4L			
	Plan funding arrangement (check all that apply) (1)	9b Plan benefit arrangement (check all the (1) Insurance (2) Code section 412(e)(3) Trust (4) General assets of the second and where indicated enter the pure) insurand	ce contracts
ıυ	Check all applicable boxes in Tua and Tub to Indicate which schedules are att	ached, and, where indicated, enter the num	mer attac	neu. (See instructions)

b General Schedules

(1)

(2)

(3)

(4)

(5)

(6)

H (Financial Information)

A (Insurance Information)C (Service Provider Information)

I (Financial Information – Small Plan)

D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

a Pension Schedules

(1)

(2)

(3)

R (Retirement Plan Information)

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

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

nurrought to EDICA agostion 400(a)(0)					Inspection		
For calendar plan year 200	09 or fiscal pla	n year beginning 01/01/2009		and er	nding 1	2/31/2009	•
A Name of plan SPEEDY AUTO GLASS HEALTH INSURANCE TRANS AMERICA GLASS, INC WELFARE BENEFITS PLAN B Three-digit plan number (PN) 501						501	
	C Plan sponsor's name as shown on line 2a of Form 5500. WASHINGTON GLASS, INC D Employer Identification Number (EIN) 91-1255564						
on a separat		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance car METROPOLITAN LIFE	rrier						
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f	From	(g) To
13-5581829	65978	103217-G	3	34	01/01/2	009	12/31/2009
2 Insurance fee and communication descending order of the		nation. Enter the total fees and to	tal commissions paid. L	ist in item 3	the agent	s, brokers, and o	ther persons in
(a) Total a	amount of com	nmissions paid		(b) To	tal amoun	t of fees paid	
		0					0
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name	and address of the agent, broker	, or other person to who	m commissi	ions or fee	s were paid	
(b) Amount of sales ar	nd base		es and other commissio	ns paid			
commissions pai	d	(c) Amount		(d) Purpose	9		(e) Organization code
	(a) Name	and address of the agent, broker	, or other person to who	m commissi	ions or fee	s were paid	
	(0)		,			- · · · · · · ·	
(b) Amount of sales ar	nd base	Fe	es and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code

Schedule A (Form 5500)	2009	Page 2- 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.	idual contracts with each c	arrier may be treated as a unit for	purposes of
4	Curre	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 e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	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			
		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	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation 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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Schedule A (Form 5500) 2009		Page 4	
Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting put the entire group of such individual contracts of	oup of employees of the same urposes if such contracts are e	xperience-rated as a unit. Where contra	
and contract type (check all applicable boxes)			
lealth (other than dental or vision)	b X Dental	C Vision	d Life insurance
emporary disability (accident and sickness)	f Long-term disability	g Supplemental unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k PPO contract	I Indemnity contract
Other (specify)			

8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b X Dental	С	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unem	oloyment	h Prescription drug	1
	ιĖ	Stop loss (large deductible)	j HMO contract	, o_ k□	PPO contract	•	I Indemnity contra	
	. L		J I I I I I I I I I I I I I I I I I I I		11 0 contract		■ Indemnity contra	Cl
	m	Other (specify)						
9	Evn	erience-rated contracts:						
•	•	Premiums: (1) Amount received		9a(1)			╡	
	<u> </u>	(2) Increase (decrease) in amount due but unpaid		9a(2)			┥	
		(3) Increase (decrease) in unearned premium res	The state of the s	9a(3)			1	
		(4) Earned ((1) + (2) - (3))	<u> </u>			9a(4)		
	b	Benefit charges (1) Claims paid				1 5(.)		
		(2) Increase (decrease) in claim reserves		- : : 			7	
		(3) Incurred claims (add (1) and (2))	<u> </u>	, , , , , , , , , , , , , , , , , , , 		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		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)		1		
		(H) Total retention	<u></u>	<u></u>		9c(1)(H)	1	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide t	penefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in c(2) .)		9e		
10) No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to o				10a		99800
	b	If the carrier, service, or other organization incurr				106		
	_	retention of the contract or policy, other than repo	orted in Part I, item 2 abov	e, report am	ount	. 10b		
	Sp	pecify 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	

Part III

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

nurought to EDICA continu 402(a)(2)					orm 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 SPEEDY AUTO GLASS HEALTH INSURANCE TRANS AMERICA GLASS, INC WELFARE BENEFITS PLAN B Three-digit plan number (PN)						501	
•	C Plan sponsor's name as shown on line 2a of Form 5500. WASHINGTON GLASS, INC D Employer Identification Number (EIN) 91-1255564						
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca UNUM PROVIDENT	rrier						
/b) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To	
01-0278678	62235	902519	18	31	01/01/2009	01/01/2010	
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.							
(a) Total a	amount of con	nmissions paid		(b) To	tal amount of fees paid		
		8349				0	
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all p	persons).			
	(a) Name	and address of the agent, broke		n commissi	ons or fees were paid		
DONALD P GILES			BOX 1886 IDERA, TX 78003				
(b) Amount of sales ar	nd hase	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
	8349					3	
	(a) Name	and address of the agent, broke	r or other person to whor	n commissi	ons or fees were paid		
	(a) Hamo	and dadiooc of the agont, proto-	, or carer person to when		one or rece were para		
(b) Amount of sales ar	(b) Amount of sales and base Fees and other commissions paid						
commissions pai	d	(c) Amount		(d) Purpose)	(e) Organization code	

Schedule A (Form 5500)	2009	Page 2- 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.	idual contracts with each c	arrier may be treated as a unit for	purposes of
4	Curre	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 e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	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			
		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	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation 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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4		

9d(1) 9d(2)

9d(3)

9e

10a

10b

125281

Schedule A (Form 5500) 2009		Page 4		
Part III 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 same e urposes if such contracts are exp	erience-rated as a unit. Wh	nere contracts	
8 Benefit 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 X Long-term disability	g Supplemental unem	ployment h	Prescription drug
i Stop loss (large deductible)	j HMO contract	k PPO contract	ı	Indemnity contract
m X Other (specify) ▶ ACCIDENTAL DEATH & DI	SMEMBERMENT	_		
9 Experience-rated contracts:				
a 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)		
(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)	
c Remainder of premium: (1) Retention charges (on 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	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	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 after retirement......

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

(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	

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	nursuant to FDICA coetion 103(a)(3)			n is Open to Public Inspection		
For calendar plan year 200	09 or fiscal pla	an year beginning 01/01/200	9	and en	ding 12	/31/2009	
A Name of plan SPEEDY AUTO GLASS I BENEFITS PLAN	HEALTH INSU	JRANCE TRANS AMERICA GL	ASS, INC WELFARE	B Three plan	e-digit number (PI	N) •	501
				D Employ 91-125		ation Number (EIN)
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrier	(d) Contract or	(e) Approximate n			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
91-0742147	68608	10376		43	01/01/20	09	12/31/2009
2 Insurance fee and comp descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com	missions and	35538 fees. (Complete as many entrie		persons).			0
		and address of the agent, broke			ons or fees	were paid	
DONALD P GILES		PO	BOX 1886 NDERA, TX 78003			·	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose)		(e) Organization code
35538			3				
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ons or fees	were paid	
(b) Amount of sales ar			ees and other commission		_		() 0
commissions pai	a	(c) Amount		(d) Purpose)		(e) Organization code

Schedule A (Form 5500) 2009 Page 2-			
(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.	idual contracts with each c	arrier may be treated as a unit for	purposes of
4	Curre	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 e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	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			
		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	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation 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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4		

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10a

10b

		Schedule A (Form 5500) 2009		F	Page 4	<u> </u>	
Pa	art III	Welfare Benefit Contract Information on the contract covers the same grant information may be combined for reporting postupe the entire group of such individual contracts.	oup of employees of the urposes if such contracts	are experien	ce-rated as a unit. Whe	ere contrac	
8	Bene	fit and contract type (check all applicable boxes)					
	a X	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	oloyment	h Prescription drug
	i 🗍	Stop loss (large deductible)	i HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)	<i>,</i> –	L			_ ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		care (eposity)					
9	Exper	ience-rated contracts:					
	a P	remiums: (1) Amount received		. 9a(1)			
	(2) Increase (decrease) in amount due but unpaid	d	. 9a(2)			
	(Increase (decrease) in unearned premium res	serve	. 9a(3)		r	
	(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid					
	,	2) Increase (decrease) in claim reserves				ı	
	(3) Incurred claims (add (1) and (2))				9b(3)	
	(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (c	n an accrual basis)		Γ		
		(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		- 443.473			
		(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	amounts were paid ir	n 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)	
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in c(2) .)		9e	

Specifi	/ nature	Ωf	coete	•
Specif	v nature	OI	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	

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

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

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

¹² 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

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

nurought to FDICA agotion 102(a)(2)					rm is Open to Public Inspection		
For calendar plan year 200	09 or fiscal pla	an year beginning 01/01/2009		and en	nding 12/3	1/2009	•
A Name of plan SPEEDY AUTO GLASS HEALTH INSURANCE TRANS AMERICA GLASS, INC WELFARE BENEFITS PLAN B Three-digit plan number (PN) 501						501	
C Plan sponsor's name a WASHINGTON GLASS, I	NC			91-125			
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca BCBSM, INC DBA BLUE		UE SHIELD OF MINNESOTA					
(b) FINI	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or o	ontract year
(b) EIN	code	identification number	policy or contract		(f) F	rom	(g) To
41-0984460	55026	8S781		42	01/01/2009	9	12/31/2009
2 Insurance fee and communication descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in item 3	the agents, b	rokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
	4769						
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
<u> </u>		and address of the agent, broke			ions or fees w	ere paid	
STEEGE & ASSOCIATES	SINC						
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code
4769				3			
	(a) Name	and address of the agent, broke	r, or other person to who	m commissi	ions or fees w	vere paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code

Schedule A (Form 5500) 2009 Page 2-			
(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.	idual contracts with each ca	rrier may be treated as a unit fo	r purposes of
4	Curre	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 e		_	
_		racts With Allocated Funds:	-	1 - 1	
	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			
		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	ating plan check here	• 🗍	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accoun	ts)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation 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	• • •		
		(3) Interest credited during the year			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4	
over(s) or members of the sa	ame (

9d(2)

9d(3)

9e

10a

10b

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	Schedule A (Form 5500) 2009		Pa	age 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 saurposes if such contracts a	re experience	e-rated as a unit. Whe	ere contract	
8 Ben	efit and contract type (check all applicable boxes))				
а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
е	Temporary disability (accident and sickness)	f Long-term disability	, g 🗍	Supplemental unemp	loyment	h Prescription drug
i	Stop loss (large deductible)	j HMO contract	~ =	PPO contract	·	I Indemnity contract
m	Other (specify)		<u>—</u>			_ ,
L						
9 Exp	erience-rated contracts:	_				
а	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)			
	(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 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					
	(G) Other retention charges					
	(H) Total retention				9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	_	_	ŀ	9c(2)	
d	Status of policyholder reserves at end of year: (— •	<u> </u>	· · · · · · · · · · · · · · · · · · ·	9d(1)	

(2) Claim reserves.....

(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 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	

MERCER 9655 SE 9655 (Address should include room or suite no.) WASHINGTON GLASS, INC 18 Name of pian SPEEDY AUTO GLASS HEALTH TRANS AMERICA GLASS, INC 0 28 Plan sponsor's name and address (employer, if for a single-employer plan) Œ Pansion Benefit Guaranty Corporation Check box if filing under: If the plan is a collectively-ba This return/report is: This return/report is for: (2) Annual Report Identification Information For calantar plan year 2009 or theat plan year beginning 01/01/2009 Department of Labor Employee Benefite Security Administration Department of the Treasury Internal Revenue Service Form 5500 S SE ISLAND 36TH ST 36TH ST Basic Plan information - enter all requested information SUITE SUITE This form is required to be filed for employee benefit plans under sections 104 and 4085 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(e) of the Infernal Revenue Code (the Code). the first return/report; a single-employer plan; a multiemployer plan; WA 103 103 Annual Return/Report of Employee Benefit Plan INSURANCE WELFARE BENEFITS ➤ Complete all entries in accordance with the instructions to the Form 5500. 98040-3732 PLAN and ending a multiple-employer plan; or a short plan year return/report (less than 12 months). automatic extension; the final return/report; a DFE (specify) Š ö 8 ត 6 plan number PN) P Effective date of plan 03/25/1985 Business code (see instructions) 327210 Sponsor's telephone number 800-638-8244 Employer identification Number (EIN) 91-1255564 Three-digit 12/31/2009 This Form is Open to Public Inspection the DFVC program; 2009 OMB Nos. 1210 - 0110 1210 - 0069 501

MERCER ISLAND

WA 98040-3732

Caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.

Under penalties of periory and other penalties set both in the instructions, I declare that I have examined this return/report, including accompanying schedules, strimmate and stock the electronic variety of this return/report, and to the best of my knowledge and below, connect, and complete. Its, as walf

Signature of DRE IO. 7. 2010 SANDY STERNOD Date Date Enter name of individual sk 10. 7. 2010 MICHAEL DARBY Enter name of individual sk Bignature of DRE Date Date

SA SA	3a Plan administrator's name and address (If same as plan sponsor, enter "Same") SAME	3b Administrator's	inistrato	or's EIN	Z
		3c Administrator's	iinistrato		telephone number
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,	, enter the	name,		4b EIN
	EIN and the plan number from the last return/report:			Τ	
Ø	Sponsor's name				4c PN
ပ	Total number of participants at the beginning of the plan year			51	166
0	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).	nd 6d).	1888		
מ	Active participants		Т	62	150
5	Retired or separated participants receiving benefits		 	66	2
ဂ	Other retired or separated participants entitled to future benefits		! 	60	
۵	Subtotal. Add lines 6a, 6b, and 6c		 	8	152
Ф	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits		<u> </u>	8	
-	Total. Add lines 6d and 6e		<u> </u>	9	
9		on plans		?	
	complete this item)	were less		9	
	100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans			I	
				•	

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:

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

(4) General assets of the sponsor	(4) General assets of the sponsor
(3) Trust	(3) Trust
(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3) insurance contracts
(1) X Insurance	(1) X Insurance
9b Plan benefit arrangement (check all that apply)	9a Plan funding arrangement (check all that apply)

5 (See instructions)

a Pension Schedules	b General Schedules	ules	
(1) R (Retirement Plan Information)	3	I	(Financial Information)
(2) MB (Multiemployer Defined Benefit Plan and Certain Money	©	-	(Financial Information · Small Plan)
Purchase Plan Actuarial Information) - signed by the plan	(2) X 4	>	(Insurance Information)
actuary	£	ဂ	(Service Provider Information)
(3) SB (Single-Employer Defined Benefit Plan Actuarial	9	0	(DFE/Participating Plan Information)
Information) · signed by the plan actuary	(6)	O	(Financial Transaction Schedules)