Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Signature of DFE

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 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

					Inspection
Part I	Annual Report Ident				
For caler	ndar plan year 2009 or fiscal pl	an year beginning 01/01/2009	9	and ending	12/31/2009
A This r	eturn/report is for:	a multiemployer plan;	a multip	ole-employer plan; or	
		a single-employer plan;	a DFE	(specify)	
		_	_		
B This r	eturn/report is:	the first return/report;	the fina	I return/report;	
		an amended return/repo	ort; a short	plan year return/report	(less than 12 months).
C If the	plan is a collectively-bargained	d plan, check here			
D Chec	k box if filing under:	X Form 5558;	automa	tic extension;	the DFVC program;
	3	special extension (enter	description)		
Part I	I Basic Plan Inform	ation—enter all requested info	. ,		
	ne of plan	and an requested line	Jiiiddoii		1b Three-digit plan
		Y, INC. EMPLOYEE BENEFIT F	PLAN		number (PN) ▶ 504
					1c Effective date of plan 01/01/1987
2a Plan	sponsor's name and address	(employer, if for a single-emplo	yer plan)		2b Employer Identification
`	ress should include room or su	,			Number (EIN)
WESTER	RN DISTRIBUTING COMPAN'	Y, INC.			84-0376087 2c Sponsor's telephone
					number
4955 RΔ	NNOCK ST	4055 [BANNOCK ST		303-388-5755
	R, CO 80216		ER, CO 80216	2d Business code (see	
					instructions) 424800
Caution	: A penalty for the late or inc	omplete filing of this return/re	eport will be assessed	d unless reasonable ca	ause is established.
Under pe	enalties of perjury and other pe	nalties set forth in the instructio	ns, I declare that I have	e examined this return/r	report, including accompanying schedules,
statemer	its and attachments, as well as	s the electronic version of this re	eturn/report, and to the	best of my knowledge a	and belief, it is true, correct, and complete.
SIGN HERE	Filed with authorized/valid elec	ctronic signature.	10/12/2010	SHELLY JOHNSON	N
HEKE	Signature of plan administr	rator	Date	Enter name of indivi	idual signing as plan administrator
SIGN					
HERE	Signature of employer/plan	sponsor	Date	Enter name of indiv	idual signing as employer or plan sponsor
SIGN					
HERE					

Date

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)	F	Page 2		
	Plan administrator's name and address (if same as plan sponsor, enter "S STERN DISTRIBUTING COMPANY, INC.	Same")		84	dministrator's EIN -0376087
	5 BANNOCK ST NVER, CO 80216			nı	dministrator's telephone umber 3-388-5755
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	urn/report filed fo	or this plan, enter the name, El	N and	4b EIN
а	Sponsor's name				4c PN
5	Total number of participants at the beginning of the plan year			5	591
6	Number of participants as of the end of the plan year (welfare plans compl	lete only lines 6a	a, 6b, 6c, and 6d).		
а	Active participants			6a	544
b	Retired or separated participants receiving benefits			6b	6
	Other retired or separated participants entitled to future benefits			6с	
	Subtotal. Add lines 6a , 6b , and 6c				550
	Deceased participants whose beneficiaries are receiving or are entitled to				
f	Total. Add lines 6d and 6e			6f	550
	Number of participants with account balances as of the end of the plan year			<u>01</u>	
g	complete this item)			6g	
h	Number of participants that terminated employment during the plan year wiless than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (or	nly multiemploye	er plans complete this item)	···· 7	
_	If the plan provides pension benefits, enter the applicable pension feature the plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E 4H 4L				
	Plan funding arrangement (check all that apply) (1)	(1) (2) (3) (4)	enefit arrangement (check all the line of	s) insurances	ce contracts
а	Pension Schedules		al Schedules	t' \	
	(1) R (Retirement Plan Information)	(1)	H (Financial Info	rmation)	

(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)

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

(1)

(2)

(3)

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

	Inspection						
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009							
A Name of plan WESTERN DISTRIBUTION	NG COMPANY,	INC. EMPLOYEE BENEFIT PLA	NI .	e-digit number (PN)	504		
C Plan sponsor's name a WESTERN DISTRIBUTION			D Emplo 84-03	oyer Identification 76087	n Number (EIN)		
			overage, Fees, and Com unit in Parts II and III can be rep		ovide information for each contract Schedule A.		
1 Coverage Information:							
(a) Name of insurance ca		NCE COMPANY					
(L) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) Fro	m (g) To		
35-0472300	70254	000010021434000	647	04/01/2008	03/31/2009		
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 amount of commissions paid (b) Total amount of fees paid							
19357							
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).							
	(a) Name a		or other person to whom commiss	sions or fees wer	e paid		
MARTIN-DARLEY INDEF	PENDENT BKR:		DX 3041 ETON, CO 80161				
(b) Amount of sales ar	nd base	Fees	s and other commissions paid				
commissions pa		(c) Amount	(d) Purpos	(e) Organization code			
	1321				3		
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	sions or fees wer	re paid		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid RONALD D. MARTIN PO BOX 3041 LITTLETON, CO 80161							
(b) Amount of sales ar	nd base	Fees	s and other commissions paid				
commissions pa		(c) Amount	(d) Purpos	е	(e) Organization code		
	18036				3		
For Donomicals Dodinatio	n Act Notice o	nd OMP Control Numbers see	the instructions for Form FEOO		Sahadula A (Farm FEOO) 2000		

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	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
	I	Fees and other commissions paid						
(b) Amount of sales and base		(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	rt II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with ea	ch carrier may be treated as a unit for t	ourposes of
_		this report.			1
		ent value of plan's interest under this contract in the general account at year			
_	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (Cont	racts With Allocated Funds:			
	a	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		00	
		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 (racts With Unallocated Funds (Do not include portions of these contracts ma		CCOUNTS)	
			ite participation guara		
	u			neo -	
		(3) guaranteed investment (4) other			
	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)	C
	d ·	Total of balance and additions (add b and c(6))			
	e I	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	- (0)		
		(4) Other (specify below)	. 7e(4)		
)			
		,			
		(5) Total deductions		. ,	C
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4		

X No

Yes

Schedule A (Fo	ບເຄານ	(U) Z	บบษ
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Part III

Part IV

Welfare Benefit Contract Information

	41 6 11	If more than one contract covers the same gr information may be combined for reporting po the entire group of such individual contracts of	urpose	s if such	contracts	are experi	ienc	ce-rated as a unit. Who	ere contrac		
8	Ben	efit and contract type (check all applicable boxes)									
	а	Health (other than dental or vision)	b	Dental			сГ	Vision		d X Life insurance	
	е	Temporary disability (accident and sickness)	f∏		erm disabili	ty (9	Supplemental unemp	loyment	h Prescription drug	
	i Ì	Stop loss (large deductible)	iΠ	HMO co			k 🗆	PPO contract	•	I Indemnity contrac	t
	m		, 🗆				·]			•
	[Guici (specify)									
9	Ехре	erience-rated contracts:									
		Premiums: (1) Amount received				9a(1)					
		(2) Increase (decrease) in amount due but unpaid									
		(3) Increase (decrease) in unearned premium res									
		(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			,		. 1				
		(A) Commissions				9c(1)(A					
		(B) Administrative service or other fees				9c(1)(E					
		(C) Other specific acquisition costs				9c(1)(C					
		(D) Other expenses				9c(1)(D 9c(1)(E				_	
		(E) Charges for risks as other continuous					_				
		(F) Charges for risks or other contingencies.									
		(G) Other retention charges(H) Total retention							9c(1)(H	1	
		(2) Dividends or retroactive rate refunds. (These			_		_)	-
	А	Status of policyholder reserves at end of year: (1							9c(2)		
	d	(2) Claim reserves							9d(1) 9d(2)		
		(3) Other reserves							9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no							9e		
10	_	nexperience-rated contracts:	Ot intoit	ado dirio	dit ontoroc	4 III O(2) .)			<u> </u>		
	a	Total premiums or subscription charges paid to c	carrier.						10a		96788
	b	If the carrier, service, or other organization incurr									
		retention of the contract or policy, other than repo	orted i	n Part I,	item 2 abo	ve, report	am	ount	10b		
	Sp	ecify nature of costs									

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

Provision of Information

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

			RISA section 103(a)(2).	11113 1 01	m 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 WESTERN DISTRIBUTION	NG COMPANY	, INC. EMPLOYEE BENEFIT PLA	NI .	e-digit number (PN)	504				
	C Plan sponsor's name as shown on line 2a of Form 5500. WESTERN DISTRIBUTING COMPANY, INC. D Employer Identification Number (EIN) 84-0376087								
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance ca		E COMPANY							
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or co	ontract year				
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To				
35-0472300	70254	000010021435000	647	04/01/2008	03/31/2009				
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 amount of commissions paid (b) Total amount of fees paid									
31134 0									
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).									
		and address of the agent, broker,		ions or fees were paid					
MARTIN-DARLEY INDEF	MARTIN-DARLEY INDEPENDENT BKRS PO BOX 3041 LITTLETON, CO 80161								
(b) Amount of sales ar	nd base		s and other commissions paid						
commissions pa		(c) Amount	(d) Purpose (e) Organizat						
	2245				3				
	(a) Name a	and address of the agent, broker,	or other person to whom commiss	ions or fees were paid					
RONALD D. MARTIN		P O Bi LITTLI	OX ETON, CO 80161						
(b) Amount of sales ar	nd hase	Fee	s and other commissions paid						
commissions pa		(c) Amount	(d) Purpose	(d) Purpose					
	28889				3				
For Panerwork Reduction	n Act Notice	and OMB Control Numbers, see	the instructions for Form 5500	Sch	edule A (Form 5500) 2009				

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	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
	I	Fees and other commissions paid						
(b) Amount of sales and base		(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	rt II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with ea	ch carrier may be treated as a unit for t	ourposes of
_		this report.			1
		ent value of plan's interest under this contract in the general account at year			
_	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (Cont	racts With Allocated Funds:			
	a	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		00	
		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 (racts With Unallocated Funds (Do not include portions of these contracts ma		CCOUNTS)	
			ite participation guara		
	u			neo -	
		(3) guaranteed investment (4) other			
	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)	C
	d ·	Total of balance and additions (add b and c(6))			
	e I	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	- (0)		
		(4) Other (specify below)	. 7e(4)		
)			
		,			
		(5) Total deductions		. ,	C
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4		

Schedule A (Fo	ບເຄານ	(U) Z	บบษ
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Pa	If more than one contract covers the same grinformation may be combined for reporting puthe entire group of such individual contracts w	oup of employees of the s rposes if such contracts a	are experienc	ce-rated as a unit. Wh	ere contract				
8	Benefit and contract type (check all applicable boxes)								
	a Health (other than dental or vision)	b Dental	С	Vision		d Life insurance			
	e Temporary disability (accident and sickness)	Temporary disability (accident and sickness) $\mathbf{f} \ \overline{\mathbb{N}}$ Long-term disability $\mathbf{g} \ \overline{\mathbb{N}}$ Supplemental unemployment \mathbf{h}							
	i Stop loss (large deductible)	I Indemnity contract							
	m ☐ Other (specify) ▶	j HMO contract	k [_	PPO contract					
9	Experience-rated contracts:								
	a Premiums: (1) Amount received		9a(1)						
	(2) Increase (decrease) in amount due but unpaid		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)		1				
	(3) Incurred claims (add (1) and (2))				9b(3)				
	(4) Claims charged	. 9b(4)							
	c Remainder of premium: (1) Retention charges (or								
	(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		2 (1)(1)						
	(H) Total retention	_	_		9c(1)(H)				
	(2) Dividends or retroactive rate refunds. (These	9c(2)							
	d Status of policyholder reserves at end of year: (1)	9d(1)							
	(2) Claim reserves								
	(3) Other reserves								
	e Dividends or retroactive rate refunds due. (Do no	t include amount entered	in c(2) .)		. 9e				
10	Nonexperience-rated contracts:								
	a Total premiums or subscription charges paid to carrier					155671			
		b 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								

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

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

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This Form is Open to Public Inspection									
For calendar plan year 200	For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009								
A Name of plan WESTERN DISTRIBUTING COMPANY, INC. EMPLOYEE BENEFIT PLAN B Three-digit plan number (PN) 504									
C Plan sponsor's name a WESTERN DISTRIBUTION				D Emplo	oyer Identificati 76087	on Number	(EIN)		
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information:									
(a) Name of insurance ca			(a) Annu instant			Dalianas			
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate n persons covered a policy or contract	at end of	(f) F	•	(g) To		
06-6033492	60054	876410	13	·	04/01/2008	3	03/31/2009		
2 Insurance fee and composition 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		
		nmissions paid		(b) To	otal amount of	fees paid			
		9252					0		
3 Persons receiving com		fees. (Complete as many entrie							
RONALD D MARTIN	(a) Name		ir, or other person to who BOX 3041 FLETON, CO 80161	m commiss	ions of fees w	ere paid			
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid					
commissions paid (c) Amount (d) Purpose					(e) Organization code				
	9252						3		
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees w	ere paid			
	(a) remove		,						
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid					
commissions pa	id	(c) Amount		(d) Purpose	е		(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	(e) Organization				
(b) Amount of sales and base commissions paid	(b) Altiount of sales and base						
(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) Organ							
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	(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	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

Pa	rt II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with ea	ch carrier may be treated as a unit for t	ourposes of
_		this report.			1
		ent value of plan's interest under this contract in the general account at year			
_	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (Cont	racts With Allocated Funds:			
	a	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		00	
		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 (racts With Unallocated Funds (Do not include portions of these contracts ma		CCOUNTS)	
			ite participation guara		
	u			neo -	
		(3) guaranteed investment (4) other			
	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)	C
	d ·	Total of balance and additions (add b and c(6))			
	e I	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	- (0)		
		(4) Other (specify below)	. 7e(4)		
)			
		,			
		(5) Total deductions		. ,	C
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Schedule A (Form 5500) 2009	Page 4	
information may be combined for reporting purpos	of employees of the same employer(s) or members of the same employee organization(s), es if such contracts are experience-rated as a unit. Where contracts cover individual emplach carrier may be treated as a unit for purposes of this report.	

	Schedule A	(Form	5500	2009
--	------------	-------	------	------

Part III

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

8 E	Benefit	and contract type (check all applicable boxes)						
á	a 🗍 I	Health (other than dental or vision)	b X Dental	С	Vision		d Life insurance	
•	• ∏·	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unemple	oyment	h Prescription drug	
i	Ī;	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
r	n 🗍	Other (specify)		_	•			
9 E	xnerie	ence-rated contracts:						
_	•	emiums: (1) Amount received		9a(1)			_	
		Increase (decrease) in amount due but unpaid		9a(2)				
		Increase (decrease) in unearned premium reso		9a(3)				
	` ') Earned ((1) + (2) - (3))	· ·			9a(4)		_
		enefit charges (1) Claims paid		9b(1)	1	,		
) Increase (decrease) in claim reserves	ľ	(-)				
	` ') Incurred claims (add (1) and (2))				9b(3)		_
	` '	Claims charged			F	9b(4)		_
	` '	emainder of premium: (1) Retention charges (or			<u> </u>			
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees	ľ	9c(1)(B)				
		(C) Other specific acquisition costs	ľ	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	amounts were paid in	cash, or	credited.)	9c(2)		
	d St	tatus of policyholder reserves at end of year: (1)	Amount held to provide	penefits after	retirement	9d(1)		_
) Claim reserves	·		-	9d(2)		_
	(3	Other reserves				9d(3)		_
	e ò	, ividends or retroactive rate refunds due. (Do no	ot include amount entered	in c(2) .)		9e		_
10		xperience-rated contracts:		• • •				
	а то	otal premiums or subscription charges paid to ca	arrier			10a	2885	61
	b If	the carrier, service, or other organization incurre	ed any specific costs in co	onnection wit	h the acquisition or			_
	re	tention of the contract or policy, other than repo	orted in Part I, item 2 abov	e, report am	ount	10b		
	Spec	ify nature of costs						
Par	t IV	Provision of Information						_
11	Did th	ne insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	⁄es	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 Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). 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 WESTERN DISTRIBUTING COMPANY, INC. EMPLOYEE BENEFIT PLAN B Three-digit plan number (•	N) •	504	
C Plan sponsor's name as shown on line 2a of Form 5500. WESTERN DISTRIBUTING COMPANY, INC. D Employer Identification Number (EIN) 84-0376087						EIN)		
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:								
(a) Name of insurance ca GREAT WEST LIFE & AN		RANCE COMPANY (d) Contract or	(e) Approximate nu			Policy or co	intract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To	
84-0467907	68322	357318	57	,	04/01/20	08	03/31/2009	
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 :	amount of cor	nmissions paid		(b) Tot	tal amount	of fees paid		
30000 0 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).								
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
RONALD D MARTIN PO BOX 3041 LITTLETON, CO 80161								
(b) Amount of sales a	nd hase	F	ees and other commission	s paid				
commissions paid (c) Amount (d) Purpose					(e) Organization code			
	30000						3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
	. ,	<u> </u>				·		
(b) Amount of sales a			ees and other commission				() 0	
commissions pa	ıd	(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	(e) Organization				
(b) Amount of sales and base commissions paid	(b) Altiount of sales and base						
(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) Organ							
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	(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	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

Pa	rt II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with ea	ch carrier may be treated as a unit for t	ourposes of
_		this report.			1
		ent value of plan's interest under this contract in the general account at year			
_	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (Cont	racts With Allocated Funds:			
	a	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		00	
		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 (racts With Unallocated Funds (Do not include portions of these contracts ma		CCOUNTS)	
			ite participation guara		
	u			neo -	
		(3) guaranteed investment (4) other			
	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)	C
	d ·	Total of balance and additions (add b and c(6))			
	e I	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	- (0)		
		(4) Other (specify below)	. 7e(4)		
)			
		,			
		(5) Total deductions		. ,	C
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4		

X No

Yes

Part III

Part IV

Welfare Benefit Contract Information

e ☐ Temporary disability (accident and sickness)	ntal unemployment h Prescription drug	Vision					
e Temporary disability (accident and sickness) i Stop loss (large deductible) j HMO contract k PPO contract l Indemnity co m Other (specify) Experience-rated contracts: a Premiums: (1) Amount received	ntal unemployment h Prescription drug	Vision			and contract type (check all applicable boxes	B Be	8
i			С	b Dental	Health (other than dental or vision)	а	
i		Supplemental unemployme	disability g	f Long-term	Temporary disability (accident and sickness)	е	
## Dither (specify) ## Dithe				=		i	
9 Experience-rated contracts: a Premiums: (1) Amount received]		, 🗆		m	
a Premiums: (1) Amount received					(-1 7)		
(2) Increase (decrease) in amount due but unpaid					nce-rated contracts:	9 Exp	9
(3) Increase (decrease) in unearned premium reserve			9a(1)		miums: (1) Amount received	а	
(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) 9b(4) C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions 9c(1)(A) 9c(1)(B) (C) Other specific acquisition costs 9c(1)(B) (C) Other specific acquisition costs 9c(1)(C) (D) Other expenses 9c(1)(B) (E) Taxes 9c(1)(E) (G) Other retention charges 9c(1)(E) (G) Other retention charges 9c(1)(F) (G) Other retention charges 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 paid in cash, or credited.) 9c(2) (G) Claim reserves 9d(2) (G) (G) (G) (G) (G) (G) (G) (G) (G) (G			9a(2)	d	Increase (decrease) in amount due but unpa		
b Benefit charges (1) Claims paid			9a(3)	serve	Increase (decrease) in unearned premium re		
(2) Increase (decrease) in claim reserves	9a(4)	9a					
(3) Incurred claims (add (1) and (2)) (4) Claims charged					• , , ,	b	
(4) Claims charged	21 (2)				•		
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)(F) (H) Total retention 9c(1)(H) (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 benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or							
(A) Commissions	90(4)	90			•	_	
(B) Administrative service or other fees					- · · · · · · · · · · · · · · · · · · ·	C	
(C) Other specific acquisition costs					()		
(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 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 9d(1) (2) Claim reserves 9d(2) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or			0 (4)(0)		()		
(E) Taxes			2 (1)(2)				
(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 paid in cash, or 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) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or					•		
(G) Other retention charges 9c(1)(G) (H) Total retention 9c(1)(H) (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 benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or			2 (1)(=)		()		
(H) Total retention							
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9c(1)(H)	9c(1					
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9c(2)	credited.) 9c	paid in cash, or	amounts were) Dividends or retroactive rate refunds. (Thes		
(2) Claim reserves 9d(2) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or			. —	_		d	
(3) Other reserves	` '		•	•			
10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier					•		
a Total premiums or subscription charges paid to carrier	9e	9	t entered in c(2) .)	ot include amoun	vidends or retroactive rate refunds due. (Do i	е	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or					xperience-rated contracts:	10 N	1
	10a 269848	10		carrier	otal premiums or subscription charges paid to	а	
retention of the contract or policy, other than reported in Part I, item 2 above, report amount		•		, ,	, ,	b	
	10b	ount <u>10</u>	m 2 above, report amo	orted in Part I, ite		_	
Specify nature of costs ▶					ity nature of costs 🕨	٤	

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

Provision of Information

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

nursuant to EDICA continu 102(a)(2)					n is Open to Public Inspection		
For calendar plan year 20	09 or fiscal pla	an year beginning 01/01/200	9	and en	nding 12	/31/2009	
A Name of plan WESTERN DISTRIBUTION	G COMPAN	Y, INC. EMPLOYEE BENEFIT F	PLAN		e-digit number (PI	N) •	504
C Plan sponsor's name a WESTERN DISTRIBUTION				D Employ 84-037		ation Number (EIN)
		rning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrier	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
06-1227840	39616	12065960		68	04/01/20	08	03/31/2009
2 Insurance fee and com- descending order of the		nation. Enter the total fees and t	total 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	fees. (Complete as many entrie		nersons)			0
• I crosmo receiving com		and address of the agent, broke			ions or fees	were paid	
RONALD D MARTIN	(2)	PO	BOX 3041 TLETON, CO 80161			word pand	
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose)		(e) Organization code
	1825						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ons or fees	were paid	
	(3)		,				
(b) Amount of sales ar			ees and other commission				
commissions pa	id	(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	rt II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with ea	ch carrier may be treated as a unit for t	ourposes of
_		this report.			1
		ent value of plan's interest under this contract in the general account at year			
_	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (Cont	racts With Allocated Funds:			
	a	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		00	
		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 (racts With Unallocated Funds (Do not include portions of these contracts ma		CCOUNTS)	
			ite participation guara		
	u			neo -	
		(3) guaranteed investment (4) other			
	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)	C
	d ·	Total of balance and additions (add b and c(6))			
	e I	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	- (0)		
		(4) Other (specify below)	. 7e(4)		
)			
		,			
		(5) Total deductions		. ,	C
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page	4

X No

Yes

	If more than one contract covers the same grainformation may be combined for reporting puthe entire group of such individual contracts of	urposes if such contracts	are experience	ce-rated as a unit. Wi	nere contrac		es,
8 F	Benefit and contract type (check all applicable boxes)	_		_		_	
;	Health (other than dental or vision)	b Dental	c×	Vision		d Life insurance	
(Temporary disability (accident and sickness)	f Long-term disabil	ity g	Supplemental unem	ployment	h Prescription drug	
į	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m ☐ Other (specify) ▶	, <u> </u>		-		, , ,	
9 E	xperience-rated contracts:						
7	Premiums: (1) Amount received		. 9a(1)		48101		
	(2) Increase (decrease) in amount due but unpaid	d				_	
	(3) Increase (decrease) in unearned premium res	erve	. 9a(3)		1		
	(4) Earned ((1) + (2) - (3))				9a(4)		8101
	b Benefit charges (1) Claims paid				34556		
	(2) Increase (decrease) in claim reserves		. 9b(2)		1		
	(3) Incurred claims (add (1) and (2))					34	4556
	(4) Claims charged				9b(4)		
	c Remainder of premium: (1) Retention charges (c					_	
	(A) Commissions		// /		40404	_	
	(B) Administrative service or other fees				10101	_	
	(C) Other specific acquisition costs		9c(1)(C)			_	
	(D) Other expenses		9c(1)(D)			_	
	(E) Taxes		2 (1)(=)			_	
	(F) Charges for risks or other contingencies.		0 (4)(0)				
	(G) Other retention charges		9c(1)(G)				2404
	(H) Total retention	_	_		- ` ` ` ` `	10	0101
	(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	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)	8	3639
	(3) Other reserves				9d(3)		
	e Dividends or retroactive rate refunds due. (Do n	ot include amount entere	d in c(2) .)		9e		
10	Nonexperience-rated contracts:						
	a Total premiums or subscription charges paid to or	arrier			10a		
	b If the carrier, service, or other organization incur				4.01		
		orted in Part I, item 2 abo	ve, report am	ount	10b		
	If the carrier, service, or other organization incurs retention of the contract or policy, other than represent the specify nature of costs				10b		

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

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 Three-digit
WESTERN DISTRIBUTING COMPANY, INC. EMPLOYEE BENEFIT PLAN	plan number (PN) 504
0.7	
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
WESTERN DISTRIBUTING COMPANY, INC.	84-0376087
Part I Service Provider Information (see instructions)	
You must complete this Part, in accordance with the instructions, to report the information re or more in total compensation (i.e., money or anything else of monetary value) in connection	quired for each person who received, directly or indirectly, \$5,000 with services rendered to the plan or the person's position with the
plan during the plan year. If a person received only eligible indirect compensation for which	
answer line 1 but are not required to include that person when completing the remainder of t	his Part.
1 Information on Persons Receiving Only Eligible Indirect Compensati	
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of the	
indirect compensation for which the plan received the required disclosures (see instructions	for definitions and conditions) Yes No
b If you answered line 1a "Yes," enter the name and EIN or address of each person providing received only eligible indirect compensation. Complete as many entries as needed (see inst	
(b) Enter name and EIN or address of person who provided you dis	closures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you dis	closure on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disc	closures on eligible indirect compensation
(4)	,
(b) Enter name and EIN or address of person who provided you disc	closures on eligible indirect compensation
(w) Enter hame and Ent of dudices of person who provided you dist	2.332.33 C. Oligibio Italioot compolication

(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

answered	f "yes" to line 1a above	e, complete as many e	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in to	otal compensation
		(a) Enter name and EIN or	address (see instructions)		
GREAT-WI	EST HEALTHCARE	<u> </u>		<u> </u>		
84-046790	7					
(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?
12	NONE	215790	Yes ☐ No 🗵	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employer 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? Yes No	(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
_		(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 4- 1	Page	4-	1
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(a) Enter name and EIN or address (see instructions)							
			,	,			
(b) Service	(c) Relationship to	(d) Enter direct	(e) Did service provider	(f) Did indirect compensation	(g) Enter total indirect	(h) Did the service	
Code(s)	employer, employee	compensation paid by the plan. If none, enter -0	receive indirect compensation? (sources other than plan or plan	include eligible indirect compensation, for which the plan received the required	compensation received by service provider excluding eligible indirect	provider give you a formula instead of an amount or	
	a party-in-interest		sponsor)	disclosures?		estimated amount?	
			Yes No 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	
	person known to be	by the plan. If none, enter -0	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 (f). If none, enter -0	estimated amount?	
			Yes No	Yes ☐ No ☐		Yes No	
						100 [] 110 []	
(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	
	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 (f). If none, enter -0	estimated amount?	
			Yes No	Yes No		Yes No	

Schedule	C	(Form	5500)	2009
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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.

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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	(b) Nature of	(c) Describe the information that the service provider failed or refused to		
instructions)	Service Code(s)	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 EIN:
С	Position:	
d	Address:	e Telephone:
Ex	xplanation:	
а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:
Ex	xplanation:	
а	Name:	b EIN:
C	Position:	D LIN.
d	Address:	e Telephone:
Ex	xplanation:	
а	Name:	b EIN;
C	Position:	D Enti
d	Address:	e Telephone:
-		
Ex	xplanation:	
а	Name:	b EIN;
C	Position:	
d	Address:	e Telephone:
Ex	xplanation:	

	Form 6500	Annual Return/Report of Employee Benefit Plan			OMB Nos. 1210-0110
	Internal Revoyage Service	This form is required to be slied for employee benefit plans under sections 104 and 4095 of the Employee Registrated Employee Sections 104			04
	Dopselment of Labor Employee Banadle Security Administration	sections 6047(s), and 6056(a) of the Internal Revenue Code (the Code).			and 2009
P	islan Berusii Guarenty Corporation		Complete all entries	In accordance with	
SP)	nti Annual Repo	rt Identification	the Instructions to	o the Form 5500.	This Form is Open to Public Inspection
Fox	calendar plan year 2009 or fi	902) bian year begin	in i		
Α	This return/report is for:	a multiernploye		and ending	
		X a single-employ		a muldpie-employer a DFE (specify)	pian; or
B	This rotum/report is:	the first return/r		the final return/repor	- t,
C	If the plante a pollowania	an amended re	turu/report;		um/report (less than 12 months).
Ď	If the plan is a collectively-back Check box if filing under:	maned plan, check	hore		- Topos (was u)al 12 modus).
	CONTRACT POST IN HIRITING DIFFICIT	X Form 5558;		eutomatic extension	[] (be 7)[7/6]
	¥III Pagio D(1-¢	i special ordensic	ਸ਼ (entar description)		the DFVC program;
	Name of plan	ormation -enter a	requested Information	· · · · · · · · · · · · · · · · · · ·	
			·	15 1	hree-digit
PMI	TERN DISTRIBUT	ING COMPA	NY, INC.		. ".
Ent	LOYEE BENEFIT	PLAN		10 E	flective date of plan
7=					<u>/01/</u> 1987
2 A	Plan spongor's name and ac (Address should include roo	idræs (employer, if f	r a singia-employer plan)	26.5	01/198/
	t the state of the	··· or sume (16),		1	imployer Identification
WES	TERN DISTRIBUT	'ING COMPAI	Y, INC.		lumber (EIN)
DEN	VER	CO	80216	204-	<u>-0376087</u>
	•				ponsor's telephone
					Umber
				1 303	<u>-389-5755</u>
					usinėsa code (see
				1 .	skuctions)
				424	800
					
Caut	on: A penalty for the late or	Incomplete ##	44 4 4	:	
Under	Densition of custom and advan-		rus ternaviobout will pe i	ssassed unless reasonable cause	is established.
atoten	ents and effectionents, as well as	Tro electronic version o	structions, I doctore that these fithis return/report, and to the	e examined this return/report, including a bast of my knowledge and bollef, it is true	ccompanying echedules. c. correct, and complete.
SIGN HERE	lms		10/11/10	CHOOLS B	
	Signature of pilon administ	rator	Date	Enter name of individual signing a	as plan administrator
SIGN HERE	-Vie la		10/11/10	i 11 -	WES
1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 /	Signature of employed plan	sponsor	Date		
7.76			-	Enter name of individual signing a	s emproyer or blan aponsor

Entor name of individual algoing as DFE For Paperwork Reduction Act Notice and OMS Control Numbers, see the instructions for Form 5500.

Date

Form 5500 (2009) v.092307.1

SIGN HERE Signature of DFE

Form 5500 (2009)		
Page 2		
3 a Flan administrator's name and address (if same as plan sponsor, enter "Same")	3b Administrato	ut- miri
	OD VENNINGERALD	ICE EIN
	3c Administrato	r's telephone
	number	,
4 If the name end/or FIM of the collection	, ,	
4 If the name end/or EIN of the plan sponsor has changed since the last return/report filed it EIN and the plan number from the last return/report;	or this plan, enter the name.	46 EIN
a Sponsor's frame	•	1-4-5
		4c PN
Total number of participants at the beginning of the plan year		<u> </u>
Number of participants as of the end of the plan year (welfare plans complete only lines	62 6h 6	59
a Active participants	- en' ec' auc' eq)	
a reave penuspants	· · · · · · · · · · · · · · · · · · ·	
b Retired or separated participants received to the control of the	4	54
b Retired or separated participants receiving benefits	6b	
C Other retired or separated participants entitled to future benefits		
The second of th	<u>6c</u>	·
d Subtotal, Add lines 6a, 6b, and 6c		
O Consulation	• • • • • • • • • • • • • • • • • • •	<u>55</u> 0
8 Deceased participants whose beneficiaries are receiving or are entitled to receive benefits		7.
	de	
Total. Add lines 6d and 6o	6f	550
 Number of participants with account bolimose as of the end of the plan year (only defined co complete this item) 		
complete this item)	ntilbution plans	
		<u> </u>
1 Number of participants that terminated employment during the plant year with accrued benefit less than 100% vester.	ts that were	1
Enter the total number of employers obligated to contribute to the plan (only multiemployer pl	ans complete this item) 7	
If the plan provides penalon benefits, enter the applicable penalon feature codes from the List	t of Plan Characteristic Codes in th	e instructions:
If the plan provides welfare benefits, enter the applicable waitare feature codes from the List $4A-4B-4D-4E-4H-4T$.		
4.A 4B 4D 4E 4H 4L	of Plan Characloristic Codes in the	instructions;
Plan funding arrangement (check all that apply) 9b Plan benefit (1) X insurance	it arrangement (check oil that appl	<u> </u>
··· (=) ···· (V)	insurance	וצ
(2) Code section 412(e)(3) Insurance contracts (3) Trust (2)	Code section 412(e)(3) Insurance	COntracts
(4) General assets of the snongo:	Trust	
Check all applicable boxes in 10a and 10b to indicate which schedules are stached, and, where indicated,	General assets of the aponsor	
	enter the number attached. (See Instru	ctions)
Pension Schedules b General Schedule	.	
(1) K (Retirement Plan Information)		
(2) MB (Multiemployer Defined Benefit and Certain Money Co.	H (Financial Information)	- >
Purchase Plan Actuariat Information) - algred by the plan (3) X 5	l (Financial Information Small Pla A (Insurance Information)	an)
D Schuary	C (Service Provider Information)	
(*) 28 (Oligie - Employet Defined Deposition 3.,	D (DFE/Participating Plan Informati	V1
Information) - signed by the plan actuery (6)		