Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

HERE

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	JDIIC		
Part I	Annual Report Iden	tification Information						
For caler	ndar plan year 2009 or fiscal p			and ending 06/30/2	010			
A This	return/report is for:	a multiemployer plan;	a multiple	e-employer plan; or				
		a single-employer plan;	a DFE (s	specify)				
		_	_					
B This r	return/report is:	the first return/report;	the final	return/report;				
		an amended return/report;	a short p	lan year return/report (less th	an 12 months).			
C If the	plan is a collectively-bargaine	ed plan, check here						
	k box if filing under:	Form 5558;	_	c extension;	the DFVC program;			
2 000	. v o o o o o o o o o o o o o o o o o o	special extension (enter des	ш					
Part	II Rasic Plan Inform	nation—enter all requested informa	· /					
_	ne of plan	indiron enter all requested informa	ation		1b Three-digit plan			
	E FINANCIAL HEALTH & WE	ELFARE BENEFITS PLAN			number (PN) ▶	501		
					1c Effective date of pla	an		
20 Diam		- /	-1)		11/01/1970	4:		
	ress should include room or s	s (employer, if for a single-employer բ suite no.)	pian)		2b Employer Identification Number (EIN)	ation		
,	E BANK	,			91-1984151			
					2c Sponsor's telephone			
					number 206-568-7803			
	EEN ANNE AVENUE N		EN ANNE AVENUE	N	2d Business code (see			
SUITE 1 SEATTL	E, WA 98109	SUITE 100 SEATTLE	0 , WA 98109		instructions)	C		
					522110			
Caution	: A penalty for the late or in	complete filing of this return/repor	rt will be assessed	unless reasonable cause is	established.			
		enalties set forth in the instructions, I				dules,		
statemer	statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.							
SIGN HERE	Filed with authorized/valid ele	ectronic signature.	11/08/2010	NANCY STEELE				
HEKE	Signature of plan adminis	trator	Date	Enter name of individual sign	gning as plan administrator			
SIGN HERE								
HERE	Signature of employer/pla	n sponsor	Date	Enter name of individual sign	gning as employer or plan sp	onsor		
SIGN								

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

Form 5500 (2009) v.092307.1

	Form 5500 (2009)	Page 2
3a	Plan administrator's name and address (if same as plan sponsor, enter "Same")	

	Plan administrator's name and address (if same as plan sponsor, enter "Sam ATTLE BANK		3D Administrator's EIN 91-1984151				
190 SU	QUEEN ANNE AVENUE N ITE 100	3c Ac	3c Administrator's telephone number				
SE	ATTLE, WA 98109		20	6-568-7803			
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:	report filed for this plan, e	nter the name, EIN and	4b EIN 91-0495915			
	Sponsor's name ATTLE FINANCIAL GROUP			4c PN 501			
5	Total number of participants at the beginning of the plan year		5	162			
6	Number of participants as of the end of the plan year (welfare plans complete	only lines 6a, 6b, 6c, and					
а	Active participants		6a	154			
b	Retired or separated participants receiving benefits		6b	15			
С	Other retired or separated participants entitled to future benefits		6c	0			
d	Subtotal. Add lines 6a, 6b, and 6c		6d	169			
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	eeive benefits	6e	0			
f	Total. Add lines 6d and 6e	6f	169				
g	Number of participants with account balances as of the end of the plan year (complete this item)						
h	Number of participants that terminated employment during the plan year with less than 100% vested						
7	Enter the total number of employers obligated to contribute to the plan (only	multiemployer plans comp	lete this item) 7				
	 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: 4A 4B 4D 4E 4F 4H 4L 						
9a	Plan funding arrangement (check all that apply)	. — ·	ment (check all that apply))			
	(1) Insurance	(1) X Insur					
	(2) Code section 412(e)(3) insurance contracts (3) Trust	(2) Code (3) Trust	section 412(e)(3) insurance	ce contracts			
	(4) X General assets of the sponsor	ral assets of the sponsor					
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at	· · · · · · · · · · · · · · · · · · ·	ched. (See instructions)				
_				,			
a	Pension Schedules (1) R (Retirement Plan Information)	b General Schedules (1)	H (Financial Information)				
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money		(Financial Information –	Small Plan)			
	Purchase Plan Actuarial Information) - signed by the plan	` ′ ⊢	(Insurance Information)	,			
	actuary	` '	C (Service Provider Inform				
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	· · ·	D (DFE/Participating Plan				
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		G (Financial Transaction S				
		· · · <u>L</u>	,	, , , , , , , , , , , , , , , , , , ,			

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

pursuant to ERISA section 103(a)(2).							
For calendar plan year 20	09 or fiscal pla	n year beginning 07/01/2009	and e	ending 06/30/2010			
A Name of plan SEATTLE FINANCIAL HE	EALTH & WEL	FARE BENEFITS PLAN		ee-digit n number (PN)	501		
C Plan sponsor's name a SEATTLE BANK	s shown on lir	ne 2a of Form 5500.		loyer Identification Number 984151	(EIN)		
on a separat			Coverage, Fees, and Cons a unit in Parts II and III can be re				
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		E COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or o	contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To		
47-0322111	69868	GLUG 0525I	217	07/01/2009	06/30/2010		
	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 amount of commissions paid (b) Total amount of fees paid							
		1475					
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all persons).				
	(a) Name		r, or other person to whom commis	ssions or fees were paid			
MERCER HEALTH & BE	NEFITS	SUI	1 FIFTH AVENUE TE 1900 TTLE, AA 98101				
(b) Amount of sales ar	nd base	Fe	ees and other commissions paid				
commissions pa		(c) Amount	(d) Purpo	se	(e) Organization code		
1475					3		
	(a) Name	and address of the agent, broke	r, or other person to whom commis	ssions or fees were paid			
		.	, , , , , , , , , , , , , , , , , , , ,				
(b) Amount of sales ar	nd base	Fe	ees and other commissions paid				
commissions pa	id	(c) Amount	(d) Purpo	se	(e) Organization code		
(a) i dipose							

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

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may this report.				d 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		5		
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6))			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
	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 Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.							
and contract type (check all applicable boxes)							
dealth (other than dental or vision) b Dental	C Vision	d X Life insurance					
emporary disability (accident and sickness) f Long-term disabili	ity g Supplemental unemploymen	nt h Prescription drug					
Stop loss (large deductible) j ☐ HMO contract Other (specify) ► ACCIDENTAL DEATH AND DISMEMBERMENT	k PPO contract	I Indemnity contract					

8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemp	loyment	h Prescription drug	g
	ιĺ	Stop loss (large deductible)	j HMO contract		PPO contract		I Indemnity contra	
	m				l		. 🗆	
9	Expe	erience-rated contracts:						
		Premiums: (1) Amount received		9a(1)			7	
		(2) Increase (decrease) in amount due but unpaid	j	9a(2)				
		(3) Increase (decrease) in unearned premium res		9a(3)			7	
		(4) Earned ((1) + (2) - (3))	<u> </u>			9a(4)		
	b	Benefit charges (1) Claims paid				•		
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		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 o	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide be	enefits 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 i	in c(2) .)		9e		
10) No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			10a		14747
	b	If the carrier, service, or other organization incurretention of the contract or policy, other than report	, .		•	10b		
	Sr	pecify nature of costs	51104 III I WILL, IIOIII Z WOOVE	, roport and	Juli 14.	.00		

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

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

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 2009 or fiscal plan year beginning 07/01/2009 and ending 06/30/2010							
A Name of plan SEATTLE FINANCIAL HE	EALTH & WEI	LFARE BENEFITS PLAN			e-digit number (PN	N) •	501
C Plan sponsor's name a SEATTLE BANK	ıs shown on liı	ne 2a of Form 5500.		D Emplo	-	ation Number	(EIN)
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		E COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
47-0322111	69868	GUD 0525I	2	217 07/01/200		009	06/30/2010
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents,	, brokers, and	other persons in
(a) Total a	amount of con	nmissions paid		(b) To	otal amount	of fees paid	
		2334					
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
MERCER HEALTH & BE	NEFITS	SU	11 FIFTH AVENUE ITE 1900 ATTLE, AA 98101				
			and other commission	ne paid			
(b) Amount of sales ar commissions pa		(c) Amount	ees and other commissions paid (d) Purpose				(e) Organization code
	2334					3	
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
	. ,	<i>y</i> ,	,			•	
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code

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

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may this report.				d 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		5		
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6))			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)			7f	

Page 4	

Pa	art II	Welfare Benefit Contract Informat	ion					
-		If more than one contract covers the same gr	oup of employees of the s	same employ	er(s) or members of th	ne same empl	loyee organization(s), the	
		information may be combined for reporting pu					cover individual employe	es,
_	_	the entire group of such individual contracts v	vith each carrier may be ti	reated as a u	init for purposes of this	в герогт.		
8	Bene	efit and contract type (check all applicable boxes)	- 🗖	_	=		- 🗔	
	а	Health (other than dental or vision)	b Dental	С	Vision	C	Life insurance	
	е	Temporary disability (accident and sickness)	f X Long-term disabilit	y g	Supplemental unem	ployment I	n Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)						
	_	_						
9	Expe	rience-rated contracts:						
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	l	9a(2)				
		(3) Increase (decrease) in unearned premium res	erve	9a(3)				
		(4) Earned ((1) + (2) - (3))				. 9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				. 9b(3)		
		(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)		1		
		(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)		
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	l in c(2) .)		. 9e		
10) No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			. 10a	1:	5842
	b	If the carrier, service, or other organization incurr			•			
		retention of the contract or policy, other than repo	orted in Part I, item 2 abov	e, report am	ount	. 10b		
	Sp	ecify nature of costs						

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

Schedule A (Form 5500) 2009

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

					m is Open to Public Inspection		
For calendar plan year 20	09 or fiscal pla	an year beginning 07/01/2009	9	and er	nding 06/	/30/2010	
A Name of plan SEATTLE FINANCIAL HE	EALTH & WEI	LFARE BENEFITS PLAN			e-digit number (PN	N) •	501
C Plan sponsor's name a SEATTLE BANK	s shown on li	ne 2a of Form 5500.		D Emplo	-	ation Number	(EIN)
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		E COMPANY					
<i>a</i> > =	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
47-0322111	69868	GUC 0525I		46	07/01/20	009	06/30/2010
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents,	, brokers, and	other persons in
(a) Total a	amount of con	nmissions paid		(b) To	otal amount	of fees paid	
	2387						
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
		and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
MERCER HEALTH & BE	NEFITS	SU	ITE 1900 ATTLE, AA 98101				
							1
(b) Amount of sales ar			ees and other commissio				<u> </u>
commissions pa	2387	(c) Amount		(d) Purpose	9		(e) Organization code
	2307						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(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) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(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				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contrad	cts with each carrier may	be treated	d 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			5	
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6))			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)			7f	

Page 4	
(-)	

X No

Yes

(B) Administrative service	or vision) b sident and sickness) f le) j ived amount due but unpaid unearned premium reserve paid claim reserves	Long-term disability HMO contract	9a(1) 9a(2) 9a(3) 9b(1) 9b(2)	PPO contract	9a(4)	1
e Temporary disability (accining land) Temporary deductible accining land) Temporary deduction a	ivedamount due but unpaidunearned premium reserveand (2))	Long-term disability HMO contract	9a(1) 9a(2) 9a(3) 9b(1) 9b(2)	Supplemental une	employment h	Prescription drug
i Stop loss (large deductible m Other (specify) 9 Experience-rated contracts: a Premiums: (1) Amount receive (2) Increase (decrease) in a (3) Increase (decrease) in use (4) Earned ((1) + (2) - (3)) b Benefit charges (1) Claims (2) Increase (decrease) in classification (3) Incurred claims (add (1) (4) Claims charged	ived amount due but unpaid unearned premium reserve paid claim reserves and (2))	HMO contract	9a(1) 9a(2) 9a(3) 9b(1) 9b(2)	PPO contract	9a(4)	,
m ☐ Other (specify) 9 Experience-rated contracts: a Premiums: (1) Amount received: (2) Increase (decrease) in use (4) Earned ((1) + (2) - (3)) b Benefit charges (1) Claims (2) Increase (decrease) in classed: (2) Increase (decrease) in classed: (3) Incurred claims (add (1)) (4) Claims charged	ived unearned premium reserve paid claim reserves u and (2))	accrual basis)	9a(1) 9a(2) 9a(3) 9b(1) 9b(2)			Indemnity contract
9 Experience-rated contracts: a Premiums: (1) Amount receive (2) Increase (decrease) in an (3) Increase (decrease) in une (4) Earned ((1) + (2) - (3)) b Benefit charges (1) Claims (2) Increase (decrease) in claims (2) Increase (decrease) in claims (add (1)) (4) Claims charged	paid claim reserves and (2)) Retention charges (on ar	accrual basis)	9a(2) 9a(3) 9b(1) 9b(2)			
9 Experience-rated contracts: a Premiums: (1) Amount receive (2) Increase (decrease) in an (3) Increase (decrease) in une (4) Earned ((1) + (2) - (3)) b Benefit charges (1) Claims (2) Increase (decrease) in claims (2) Increase (decrease) in claims (add (1)) (4) Claims charged	paid claim reserves and (2)) Retention charges (on ar	accrual basis)	9a(2) 9a(3) 9b(1) 9b(2)			
a Premiums: (1) Amount receive (2) Increase (decrease) in an (3) Increase (decrease) in une (4) Earned ((1) + (2) - (3)) b Benefit charges (1) Claims (2) Increase (decrease) in claims (add (1) (4) Claims charged	paid claim reserves and (2)) Retention charges (on ar	accrual basis)	9a(2) 9a(3) 9b(1) 9b(2)			
(2) Increase (decrease) in au (3) Increase (decrease) in us (4) Earned ((1) + (2) - (3)) b Benefit charges (1) Claims (2) Increase (decrease) in cl (3) Incurred claims (add (1) (4) Claims charged	paid claim reserves and (2)) Retention charges (on ar	accrual basis)	9a(2) 9a(3) 9b(1) 9b(2)			
(3) Increase (decrease) in u (4) Earned ((1) + (2) - (3)) b Benefit charges (1) Claims (2) Increase (decrease) in cl (3) Incurred claims (add (1) (4) Claims charged	paid claim reserves and (2)) Retention charges (on ar	accrual basis)	9a(3) 9b(1) 9b(2)			
(4) Earned ((1) + (2) - (3)) b Benefit charges (1) Claims (2) Increase (decrease) in cl. (3) Incurred claims (add (1) (4) Claims charged	paid claim reserves and (2))	accrual basis)	9b(1) 9b(2)			
b Benefit charges (1) Claims (2) Increase (decrease) in cl (3) Incurred claims (add (1) (4) Claims charged	paid claim reserves and (2)) Retention charges (on ar	accrual basis)	9b(1) 9b(2)			
(2) Increase (decrease) in cl (3) Incurred claims (add (1) (4) Claims charged	claim reserves and (2)) Retention charges (on ar	accrual basis)	9b(2)			
(3) Incurred claims (add (1) (4) Claims charged	Retention charges (on ar	accrual basis)			21 (2)	
(3) Incurred claims (add (1) (4) Claims charged	Retention charges (on ar	accrual basis)			21.72	
(4) Claims charged) Retention charges (on ar	accrual basis)			9b(3)	
 (A) Commissions					/->	
 (A) Commissions						
(C) Other specific acqui (D) Other expenses (E) Taxes (F) Charges for risks or (G) Other retention char	ice or other fees		9c(1)(A)			
(D) Other expenses (E) Taxes(F) Charges for risks or (G) Other retention char			9c(1)(B)			
(D) Other expenses (E) Taxes(F) Charges for risks or (G) Other retention char	iisition costs		9c(1)(C)			
(E) Taxes(F) Charges for risks or (G) Other retention char		_	9c(1)(D)			
(F) Charges for risks or (G) Other retention char		Harrie Harris Ha	9c(1)(E)			
(G) Other retention char			9c(1)(F)			
					9c(1)(H)	
(2) Dividends or retroactive		_		_		
_		_		-		
d Status of policyholder reser	, , ,	•				_
(2) Claim reserves					` '	_
(3) Other reserves						
e Dividends or retroactive rate		clude amount entered i	in c(2) .)		9e	
10 Nonexperience-rated contracts					40	15011
a Total premiums or subscript	• .					15911
b If the carrier, service, or oth retention of the contract or p						
Specify nature of costs	policy, carlor alian reported	2 111 1 are 1, 110111 2 above	s, roport an			
Opecity flature of costs 7						

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

Provision of Information

Part IV

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This Form is Open to Inspection							
For calendar plan year 20	09 or fiscal pla	an year beginning 07/01/2009	9	and er	nding 06/	/30/2010	-
A Name of plan SEATTLE FINANCIAL HE	EALTH & WEI	LFARE BENEFITS PLAN			e-digit number (PN	N) •	501
C Plan sponsor's name a SEATTLE BANK	s shown on li	ne 2a of Form 5500.		D Emplo		ation Number	EIN)
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		E COMPANY					
<i>a</i> > =	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
47-0322111	69868	GVTL 0525I		67	07/01/20	09	06/30/2010
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents,	brokers, and	other persons in
(a) Total a	amount of con	nmissions paid		(b) To	otal amount	of fees paid	
		4151					
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke		m commiss	ions or fees	were paid	
MERCER HEALTH & BE	NEFITS	SUI	11 FIFTH AVENUE TE 1900 ATTLE, AA 98101				
42.4		F	ees and other commissio	ne naid			
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code
	4151						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions pa		(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) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(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				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contrad	cts with each carrier may	be treated	d 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			5	
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6))			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
	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 Information If more than one contract covers the same grant information may be combined for reporting postule entire group of such individual contracts of the contracts of the contracts of the contract of the cont	oup of employees of the same urposes if such contracts are e	experience-rated as a unit. Where contr	
and contract type (check all applicable boxes)			
lealth (other than dental or vision)	b 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

	е	Temporary disability (accident and sickness) f Long-term	n disability	/ g [Supplemental unen	nployment	h Prescription drug	
	i [top loss (large deductible) j HMO contract k PPO contract			I Indemnity contract			
	m	YOU INTARY USE AND ARRO		<u></u>	_		,,,	
	[Outer (appeality)						
9	Ехре	erience-rated contracts:						
	a i	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium reserve		9a(3)				
		(4) Earned ((1) + (2) - (3))	· -			9a(4)		
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged						
	С	Remainder of premium: (1) Retention charges (on an accrual bas	is)					
		(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 amounts were	paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to	provide b	enefits after	retirement			
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)				9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier				10a	27	674
	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						

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

Specify nature of costs

8 Benefit and contract type (check all applicable boxes) **a** Health (other than dental or vision)

Part III