Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089			
Department of the Treasury Internal Revenue Service	This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).	2009			
Department of Labor Employee Benefits Security Administration	<ul> <li>Complete all entries in accordance with the instructions to the Form 5500.</li> </ul>	2009			
Pension Benefit Guaranty Corporation		This Form is Open to Public Inspection			
Part I Annual Report Ider	ntification Information				
For calendar plan year 2009 or fiscal	plan year beginning 09/01/2009 and ending 08/31/	2010			
A This return/report is for:	a multiemployer plan; a multiple-employer plan; or				
·	a single-employer plan;				
<b>B</b> This return/report is:	the first return/report; the final return/report;				
	X an amended return/report; A a short plan year return/report (less t	than 12 months).			
<b>C</b> If the plan is a collectively-bargain		ъП			
<b>D</b> Check box if filing under:	Form 5558; automatic extension;	the DFVC program;			
	special extension (enter description)				
Part II Basic Plan Infor	nation—enter all requested information				
1a Name of plan GRAYS HARBOR PAPER L.P. WEL		<b>1b</b> Three-digit plan number (PN) ▶ 501			
		<b>1c</b> Effective date of plan			
2a Plan sponsor's name and addres (Address should include room or a GRAYS HARBOR PAPER L.P.	es (employer, if for a single-employer plan) suite no.)	<b>2b</b> Employer Identification Number (EIN) 91-1602999			
		<b>2c</b> Sponsor's telephone number 360-532-9600			
801 23RD STREET HOQUIAM, WA 98550	801 23RD STREET HOQUIAM, WA 98550	<b>2d</b> Business code (see instructions) 322100			

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

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	04/27/2011	KAREN WALCZYK
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
HERE	Signature of DFE	Date	Enter name of individual signing as DFE

20	Dian administratoria name and address (if some as plan anonast anter "Come")	2h Ad	ministrator's FIN			
	Plan administrator's name and address (if same as plan sponsor, enter "Same") AYS HARBOR PAPER L.P.	<b>3b</b> Administrator's EIN 91-1602999				
	301 23RD STREET HOQUIAM, WA 98550		<b>3C</b> Administrator's telephone number 360-532-9600			
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN the plan number from the last return/report:	and	4b EIN			
а	Sponsor's name		<b>4c</b> PN			
5	Total number of participants at the beginning of the plan year	5	242			
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).					
а	Active participants	6a	260			
b	Retired or separated participants receiving benefits	6b				
с	Other retired or separated participants entitled to future benefits	6c				
d	Subtotal. Add lines <b>6a</b> , <b>6b</b> , and <b>6c</b>	6d	260			
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e				
f	Total. Add lines <b>6d</b> and <b>6e</b>	6f	260			
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g				
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h				
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7				

Form 5500 (2009)

Page 2

**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 4L

9a	9a Plan funding arrangement (check all that apply)				<b>9b</b> Plan benefit arrangement (check all that apply)			
	(1)	X	Insurance		(1)	X	Insurance	
	(2)		Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts	
	(3)		Trust		(3)		Trust	
	(4)		General assets of the sponsor		(4)		General assets of the sponsor	
10	10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)							
а	Pensio	n Scl	hedules	b	General	<u>Sc</u> h	edules	
а	Pensio (1)	n Sci	hedules R (Retirement Plan Information)	b	General (1)	Sch	edules H (Financial Information)	
а		n Sci		b		Sch		
а	(1)	n Scl	<ul> <li>R (Retirement Plan Information)</li> <li>MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan</li> </ul>	b	(1)	Scho X	H (Financial Information)	
a	(1)	n Scl	<ul><li><b>R</b> (Retirement Plan Information)</li><li><b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money</li></ul>	b	(1) (2)	Scho X	<ul><li>H (Financial Information)</li><li>I (Financial Information – Small Plan)</li></ul>	
а	(1)	n Sci	<ul> <li>R (Retirement Plan Information)</li> <li>MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan</li> </ul>	b	(1) (2) (3)	Sch X	<ul> <li>H (Financial Information)</li> <li>I (Financial Information – Small Plan)</li> <li>A (Insurance Information)</li> </ul>	

SCHEDULE	•	Incuran	ce Informatio	n			
				OM	B No. 1210-0110		
(Form 5500) Department of the Treasury This schedule is required to be filed under section							
Internal Revenue Serv		Employee Retirement Inc	come Security Act of 19	974 (ERISA	).		2009
Employee Benefits Security Ad	ministration	File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty Co	prporation	<ul> <li>Insurance companies a pursuant to E</li> </ul>	are required to provide t ERISA section 103(a)(2)		ion		m is Open to Public Inspection
For calendar plan year 20	09 or fiscal plan	year beginning 09/01/2009		and e	nding <mark>08</mark>	3/31/2010	1
A Name of plan GRAYS HARBOR PAPEI	R L.P. WELFAR	E BENEFIT & FRINGE PLAN			e-digit number (P	N) 🕨	501
C Plan sponsor's name a GRAYS HARBOR PAPE		2a of Form 5500.		D Emplo 91-160	•	cation Number	(EIN)
		ing Insurance Contract ( Individual contracts grouped as					
<b>1</b> Coverage Information:							
(a) Name of insurance ca	rrier						
LINCOLN NATIONAL LIF		COMPANY					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a		Policy or co		ontract year
(5) 2.11	code	identification number	policy or contrac		(f)	From	<b>(g)</b> To
35-0472300	70254	000010041591	246		12/01/20	008	12/31/2009
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and o	other persons in
(a) Total a	amount of comn	•		<b>(b)</b> To	otal amount	of fees paid	
		4093					0
3 Persons receiving com		es. (Complete as many entries	· · ·	. /			
PROPEL INSURANCE	(a) Name a	nd address of the agent, broker,	or other person to who PACIFIC AVE #1000	m commiss	ions or fees	s were paid	
			MA, WA 98402				
(b) Amount of sales ar			es and other commission	•			
commissions pa	4093	(c) Amount		(d) Purpos	e		(e) Organization code
	4095	0					5
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales ar	ad base	Fee	es and other commission	ns paid			
commissions pa		(c) Amount			е	(e) Organization code	

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

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

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

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

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

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

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

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of							
		this report.			, 				
-		ent value of plan's interest under this contract in the general account at year of							
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5				
6		acts With Allocated Funds:							
	а	State the basis of premium rates							
	h				Ch				
		Premiums paid to carrier			6b 6c				
		Premiums due but unpaid at the end of the year							
		retention of the contract or policy, enter amount			<b>6d</b>				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferred	d annuity						
		(3) other (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here					
7		acts With Unallocated Funds (Do not include portions of these contracts mai	• •						
				ition guarantee					
		(3) ☐ guaranteed investment (4) ☐ other ►		C C					
	b	Balance at the end of the previous year							
		Additions: (1) Contributions deposited during the year							
		(2) Dividends and credits	= (0)						
		(3) Interest credited during the year							
		(4) Transferred from separate account							
		(5) Other (specify below)							
		(6)Total additions			7c(6)				
	<b>d</b> 1	Fotal of balance and additions (add <b>b</b> and <b>c(6)</b> )							
	<b>e</b> [	Deductions:							
	(	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)						
		(2) Administration charge made by carrier	. 7e(2)						
		(3) Transferred to separate account	. 7e(3)						
	(	(4) Other (specify below)	. 7e(4)						
		▶							
	(	(5) Total deductions							
		Balance at the end of the current year (subtract e(5) from d)			<b>7</b> f				

Schedule A (Form 5500) 2009

edule A (Form 5500) 2009				Page <b>4</b>						
										Ì
elfare Ben	efit Conti	act Inform	ation							
					e		<i>(</i> )			

Part I	Welfare Benefit Contract Information	า				
	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					is cover individual employees,
8 Ben	efit and contract type (check all applicable boxes)					
а	Health (other than dental or vision) <b>b</b>	Dental	С	Vision		<b>d</b> Life insurance
е	Temporary disability (accident and sickness) <b>f</b>	Long-term disability	g	Supplemental unemp	oloyment	h Prescription drug
i	Stop loss (large deductible)	HMO contract	k	PPO contract		I Indemnity contract
m	Other (specify) VEEKLY INCOME			-		
L						
<b>9</b> Expe	erience-rated contracts:					
а	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpaid		9a(2)			
	(3) Increase (decrease) in unearned premium reserve	e	9a(3)		-	
	(4) Earned ((1) + (2) - (3))				9a(4)	
b	Benefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))				9b(3)	
	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (on a	n accrual basis)				
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			7
	(C) Other specific acquisition costs		9c(1)(C)			7
	(D) Other expenses		9c(1)(D)			7
	(E) Taxes		9c(1)(E)			7
	(F) Charges for risks or other contingencies		9c(1)(F)			7
	(G) Other retention charges		9c(1)(G)			7
	(H) Total retention				9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These am	nounts were paid in ca	ash, or	credited.)	9c(2)	
d	Status of policyholder reserves at end of year: (1) Ar	mount held to provide be	nefits after	retirement	9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
е	Dividends or retroactive rate refunds due. (Do not in	nclude amount entered ir	n <b>c(2)</b> .)		9e	
10 No	nexperience-rated contracts:					
а	Total premiums or subscription charges paid to carri	er			10a	76408
b	If the carrier, service, or other organization incurred a retention of the contract or policy, other than reported				10b	

Specify nature of costs

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

SCHEDULE		Insuran	ce Information	n		10	ИВ No. 1210-0110
(Form 5500 Department of the Trea	sury	This schedule is required					
Internal Revenue Serv		Employee Retirement Inc			).		2009
Employee Benefits Security Ac Pension Benefit Guaranty Co			ttachment to Form 55				
Fension Benefit Guaranty C	<ul> <li>Insurance companies a pursuant to E</li> </ul>	re required to provide t RISA section 103(a)(2)		tion	This Fo	rm is Open to Public Inspection	
For calendar plan year 20	09 or fiscal plan	year beginning 09/01/2009		and e	nding <mark>08</mark>	3/31/2010	•
A Name of plan GRAYS HARBOR PAPE	R L.P. WELFAR	E BENEFIT & FRINGE PLAN			e-digit number (P	N) 🕨	501
C Plan sponsor's name a GRAYS HARBOR PAPE		D Emplo 91-160	•	cation Number	(EIN)		
I       On a separa         I       Coverage Information:         (a)       Name of insurance ca	te Schedule A.	ing Insurance Contract ( Individual contracts grouped as a					
PREMERA BLUE CROS	5				-		
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a policy or contrac	it end of	(f)	Policy or c From	contract year (g) To
91-0499247	47570	1019102	260		09/01/20	009	08/31/2010
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and	other persons in
(a) Total	amount of comn	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
		26274					0
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
BRATRUD MIDDLETON			or other person to who OURTH AVENUE SUIT TLE, WA 98104		ions or fees	were paid	
(b) Amount of sales a	nd base	Fee	ees and other commissions paid			_	
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
26274		0					3
	(a) Name ar	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	

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

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

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

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

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

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

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

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

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

Schedule A (Form 5500) 2009

Page	4
raye	-

Pa	art II	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts	oup of employees urposes if such co	ntracts are experien	ce-rated as a unit. Whe	ere contracts	
8	Ben	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	<b>b</b> Dental	c	Vision	С	Life insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term	disability <b>g</b>	Supplemental unemp	loyment <b>h</b>	Prescription drug
	ιĒ	Stop loss (large deductible)				,	I Indemnity contract
	- L						
	m	Other (specify)					
9	Exne	erience-rated contracts:					
Ū	•	Premiums: (1) Amount received				2491651	
	••	(2) Increase (decrease) in amount due but unpaid					
		(3) Increase (decrease) in unearned premium res					
		(4) Earned ((1) + (2) - (3))				9a(4)	2491651
	b	Benefit charges (1) Claims paid				1844248	
		(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add (1) and (2))				9b(3)	1844248
		(4) Claims charged				9b(4)	1727811
	С	Remainder of premium: (1) Retention charges (o	n an accrual basi	s)			
		(A) Commissions		9c(1)(A)		26274	
		(B) Administrative service or other fees					
		(C) Other specific acquisition costs					
		(D) Other expenses				301335	
		(E) Taxes				71569	
		(F) Charges for risks or other contingencies.					
		(G) Other retention charges					000470
		(H) Total retention				9c(1)(H)	399178
		(2) Dividends or retroactive rate refunds. (These	amounts were	paid in cash, or	credited.)	9c(2)	364663
	d	Status of policyholder reserves at end of year: (1		•		9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
		Dividends or retroactive rate refunds due. (Do no	ot include amount	entered in <b>c(2)</b> .)		9e	
10		nexperience-rated contracts:					000000
		Total premiums or subscription charges paid to c				10a	360280
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	
		reconsider of the constact of policy, other than rep	nou in r'ait i, itel	n ∠ above, report all		100	

Specify nature of costs 🕨

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

SCHEDULE	A	Insuran	ce Informatio	n			
(Form 5500	)					ON	IB No. 1210-0110
Department of the Treas Internal Revenue Serv	sury		ed to be filed under section 104 of the Income Security Act of 1974 (ERISA).				2009
Department of Labo	r		attachment to Form 55		).		2009
Employee Benefits Security Ad Pension Benefit Guaranty Co							
	, porduon	Insurance companies a pursuant to E	ERISA section 103(a)(2)		lion	This For	m is Open to Public Inspection
For calendar plan year 20	09 or fiscal plan	year beginning 09/01/2009		and e	nding <mark>08</mark>	3/31/2010	T
A Name of plan GRAYS HARBOR PAPE	R L.P. WELFAR	RE BENEFIT & FRINGE PLAN			e-digit number (P	N) 🕨	501
-	C Plan sponsor's name as shown on line 2a of Form 5500. GRAYS HARBOR PAPER L.P.				oyer Identific	cation Number	(EIN)
		ing Insurance Contract ( Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrior						
NATIONAL UNION FIRE		TSBURGH					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
(b) EIN	code	identification number	persons covered at end policy or contract year		(f)	From	<b>(g)</b> To
25-0687550	19445	GTP 9122544	260 08		08/01/20	009	07/31/2010
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and o	other persons in
<b>(a)</b> Total a	amount of comn			<b>(b)</b> To	otal amount	of fees paid	
		143					0
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,			ions or fees	s were paid	
PROPEL INSURANCE			TH AVENUE, SUITE 32 TLE, WA 98104	200			
(b) Amount of sales ar			ees and other commissions paid				
commissions pa	id 143	(c) Amount		(d) Purpos	e		(e) Organization code
145							3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales ar	ad base	Fee	es and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	

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

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

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

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

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

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

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

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	acts with each carrier ma	av be treated	as a unit for purposes of
		this report.			, 	
-		ent value of plan's interest under this contract in the general account at year of				
-		ent value of plan's interest under this contract in separate accounts at year er		5		
6		acts With Allocated Funds:				
	а	State the basis of premium rates				
	h				Ch	
		Premiums paid to carrier			6b 6c	
		Premiums due but unpaid at the end of the year				
		retention of the contract or policy, enter amount			<b>6d</b>	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here		
7		acts With Unallocated Funds (Do not include portions of these contracts mai	• •			
				ition guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ►		C C		
	b	Balance at the end of the previous year				
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	= (0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		(6)Total additions			7c(6)	
	<b>d</b> 1	Fotal of balance and additions (add <b>b</b> and <b>c(6)</b> )				
	<b>e</b> [	Deductions:				
	(	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
	(	(4) Other (specify below)	. 7e(4)			
		▶				
	(	(5) Total deductions				
		Balance at the end of the current year (subtract e(5) from d)			<b>7</b> f	

**10** Nonexperience-rated contracts:

		Schedule A (Form 5500) 2009		Р	age 4	_	
Pa	nrt III	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	oup of employees of the s urposes if such contracts	are experiend	ce-rated as a unit. Whe	ere contract	
3	Benefit	t and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		d Life insurance
	e 🗍	Temporary disability (accident and sickness)	f Long-term disabilit	ty <b>g</b>	Supplemental unemp	loyment	h Prescription drug
	i 🗍	Stop loss (large deductible)	j HMO contract	k [	PPO contract		I Indemnity contract
		Other (specify) TRAVEL AD&D			-		
)	Experie	ence-rated contracts:					
	a Pre	emiums: (1) Amount received		9a(1)			1
	(2)	) Increase (decrease) in amount due but unpaid	۱	9a(2)			
	(3)	) Increase (decrease) in unearned premium res	erve	9a(3)			
	(4	) Earned ( <b>(1) + (2) - (3)</b> )				9a(4)	
	<b>b</b> B	enefit charges (1) Claims paid		9b(1)			
	(2	) Increase (decrease) in claim reserves		9b(2)			
	(3	) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	
	(4)	) Claims charged				9b(4)	
	C R	emainder of premium: (1) Retention charges (o		·			_
		(A) Commissions					_
		(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)			

9c(1)(H)

9c(2)

9d(1)

9d(2)

9d(3)

9e

10a

950

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	10b	
S	pecify nature of costs		

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

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

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

a Total premiums or subscription charges paid to carrier

(2) Claim reserves .....

(3) Other reserves .....

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

SCHEDULE	Α	Insuranc	ce Information	n		OM	1B No. 1210-0110
(Form 5500	)						
Department of the Treas Internal Revenue Serv		This schedule is required Employee Retirement Inc					2009
Department of Labo Employee Benefits Security Ad			ttachment to Form 55		,		2000
Pension Benefit Guaranty Co	-	Insurance companies and a second s	re required to provide t	he informat	ion	This Fee	um is Onen te Bublie
			RISA section 103(a)(2)				m is Open to Public Inspection
For calendar plan year 20	09 or fiscal plar	year beginning 09/01/2009		and er	nding 08	/31/2010	
A Name of plan GRAYS HARBOR PAPEI	R L.P. WELFAF	RE BENEFIT & FRINGE PLAN			e-digit		501
				pian	number (P	N) 🕨	
0				<b>D</b> =			/ <b>_</b>
C Plan sponsor's name a GRAYS HARBOR PAPE		2a of Form 5500.		D Emplo 91-160	•	ation Number	(EIN)
					2000		
		ing Insurance Contract C					
	e Schedule A.	Individual contracts grouped as a	a unit in Parts II and III	can be repo	orted on a s	ingle Schedule	A.
1 Coverage Information:							
(a) Name of insurance ca	rrier						
LINCOLN NATIONAL LIF	E INSURANCE	COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of policy or contract year			Policy or c	ontract year
<b>(b)</b> EIN	code	identification number			(f)	From	<b>(g)</b> To
35-0472300	70254	000010041590	246 12/01/		12/01/20	008	12/31/2009
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and	other persons in
	amount of comr	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
		3207					
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker, o		m commiss	ions or fees	were paid	
PROPEL INSURANCE			PACIFIC AVE #1000 MA, WA 98402				
		F	a and other commission				
(b) Amount of sales ar commissions pa		(c) Amount	es and other commissions paid (d) Purpose				(e) Organization code
3207		0		(u) i uipee	<u> </u>		3
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
	(a) Name a	a address of the agent, broker, t					
(b) Amount of color of	ad base	 Fee:	s and other commission	ns paid			
(b) Amount of sales an commissions pa		(c) Amount	(d) Purpose			(e) Organization code	

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

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

(b) Amount of sales and base		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

(b) Amount of sales and base		(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	r, 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

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

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

Schedule A (Form 5500) 2009

Page 4
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Pa	art III	Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same guinformation may be combined for reporting put the entire group of such individual contracts	urposes if such contracts	are experiend	ce-rated as a unit. Wh	nere contrac		
8	Bene	fit and contract type (check all applicable boxes)						
	a 🗌	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		d 🗌 Life insurance	e
	e 🗵	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Supplemental unem	plovment	<b>h</b> Prescription of	drua
	iΠ	Stop loss (large deductible)	j HMO contract	י, 5∟ k	PPO contract		I Indemnity cor	•
	<u> </u>			ĸ				IIIaci
	m	Other (specify)						
9	Exper	ience-rated contracts:						
-		remiums: (1) Amount received		9a(1)			-	
	(	2) Increase (decrease) in amount due but unpaid	J				1	
	(	3) Increase (decrease) in unearned premium res	serve	9a(3)				
	(	4) Earned ((1) + (2) - (3))		·····		. 9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
	(	2) Increase (decrease) in claim reserves		9b(2)				
	(	3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)		
	(•	4) Claims charged				. 9b(4)		
	C	Remainder of premium: (1) Retention charges (c	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees						
		(C) Other specific acquisition costs						
		(D) Other expenses		9c(1)(D)				
		(E) Taxes						
		(F) Charges for risks or other contingencies.						
		(G) Other retention charges		9c(1)(G)		-		
		(H) Total retention	······	······ <u></u> ··		. 9c(1)(H	)	
	(	(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)		
	d s	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 I	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in <b>c(2)</b> .)		. <b>9e</b>		
10	Non	experience-rated contracts:						
	a	Total premiums or subscription charges paid to o	arrier			. 10a		43952
		If the carrier, service, or other organization incur	, ,			401		
	1	retention of the contract or policy, other than rep	orted in Part I, item 2 abo	ve. report am	ount	. 10b		

Specify nature of costs 🕨

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

SCHEDULE C	Service Provider	Information	OMB No. 1210-0110
(Form 5500)			2009
Department of the Treasury Internal Revenue Service	This schedule is required to be filed unc Retirement Income Security		2003
Department of Labor Employee Benefits Security Administration	File as an attachmen	nt to Form 5500.	This Form is Open to Public
Pension Benefit Guaranty Corporation For calendar plan year 2009 or fiscal pla	n vear beginning 09/01/2009	and ending 08/31	Inspection.
	in year beginning 03/01/2009		
A Name of plan GRAYS HARBOR PAPER L.P. WELFA	RE BENEFIT & FRINGE PLAN	<b>B</b> Three-digit plan number (PN)	▶ 501
C Plan sponsor's name as shown on lir GRAYS HARBOR PAPER L.P.	ne 2a of Form 5500	D Employer Identificati 91-1602999	ion Number (EIN)
Part I Service Provider Info	rmation (see instructions)		
or more in total compensation (i.e., m plan during the plan year. If a persor answer line 1 but are not required to	rdance with the instructions, to report the info ioney or anything else of monetary value) in received <b>only</b> eligible indirect compensation include that person when completing the rem ceiving Only Eligible Indirect Con	connection with services rendered to n for which the plan received the requinainder of this Part.	the plan or the person's position with t
indirect compensation for which the p b If you answered line 1a "Yes," enter	her you are excluding a person from the remain lan received the required disclosures (see in the name and EIN or address of each person isation. Complete as many entries as neede	nstructions for definitions and condition n providing the required disclosures for	ons)Yes 🛛 No
(b) Enter nar	me and EIN or address of person who provid	led you disclosures on eligible indirec	ct compensation
(b) Enter na	me and EIN or address of person who provid	ded you disclosure on eligible indirect	t compensation
(b) Enter nar	ne and EIN or address of person who provid	ed you disclosures on eligible indirec	t compensation
(h) Enter per	ne and EIN or address of person who provid	ed vou disclosures on eligible indirec	t compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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

WASHINGTON DENTAL SERVICE

#### 91-0621480

(b)	(c)	(d)	(e)	(f)	(g)	(h)		
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect	Did the service provider give you a formula instead of an amount or estimated amount?		
12	NONE	0	Yes 🛛 No 🗌	Yes 🕺 No 🗌	37911	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 organization, or person known to be a party-in-interest	Enter direct compensation paid	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect	
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗍
(a) Enter name and EIN or address (see instructions)						

(b)	(C)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest		Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	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	Did the service provider give you a formula instead of an amount or estimated amount?
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗌

(a) Enter name and EIN or address (see instructions)						
	1	1			1	
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes 🗌 No 🗌
		(	a) Enter name and EIN or	address (see instructions)		
<b>(b)</b> Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes 🗌 No 🗍	Yes 🗌 No 🗌		Yes 🗌 No 🗍
(a) Enter name and EIN or address (see instructions)						
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes 🗌 No 🗍		Yes No

# Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
WASHINGTON DENTAL SERVICE	12	5006
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any e the service provider's eligibility the indirect compensation.
PROPEL INSURANCE 1201 PACIFIC AVE SUITE 1000 TACOMA, WA 98402	FEES AND COMMISSIONS	
91-0830024		
(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 e the service provider's eligibility the 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 e the service provider's eligibility the indirect compensation.

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

Part II Service Providers Who Fail or Refuse to	Provide Inform	nation
4 Provide, to the extent possible, the following information for ea this Schedule.	ach service provide	r who failed or refused to provide the information necessary to complete
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide

Page	7-	1
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Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)				
<b>a</b> Name:	<b>b</b> EIN:			
C Position:				
d Address:	e Telephone:			
Explanation:				
a Name:	b EIN:			
C Position: d Address:	e Telephone:			
a Address.	e relepitone.			
Explanation:				
a Name:	<b>b</b> EIN:			
C Position:				
d Address:	e Telephone:			
Fundametica				
Explanation:				
a Name:	<b>b</b> EIN;			
C Position:				
d Address:	e Telephone:			
Explanation:				

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

Explanation: