#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

> ▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2010

	, , , , , , , , , , , , , , , , , , , ,				Inis Form is Open to Pu Inspection	IDIIC		
Part I	Annual Report Iden	tification Information						
For cale	For calendar plan year 2010 or fiscal plan year beginning 03/01/2010 and ending 02/28/2011							
<b>A</b> This	return/report is for:	a multiemployer plan;	a multipl	e-employer plan; or				
		a single-employer plan;	a DFE (s	specify)				
<b>B</b> This	return/report is:	the first return/report;	the final	return/report;				
		an amended return/report;	a short p	olan year return/report (less t	han 12 months).			
C If the	plan is a collectively-bargaine	ed plan, check here						
	k box if filing under:	Form 5558;	_	ic extension;	the DFVC program;			
D Onco	K box ii iiiiiig dildei.	special extension (enter des		,	,			
Dort	II Pacia Blan Inform	nation—enter all requested informa						
Part	ne of plan	nation—enter all requested informa	ation		<b>1b</b> Three-digit plan	504		
	PUBLISHING, INC. BENEFIT	Γ PI AN			number (PN)	501		
	, , , , , , , , , , , , , , , , , , , ,				1c Effective date of pl	an		
					11/01/1988			
	•	s (employer, if for a single-employer	plan)		<b>2b</b> Employer Identification Number (EIN)	ation		
`	ress should include room or s PUBLISHING, INC.	91-1396047						
300110	T OBLIGITING, INC.					ne		
					2c Sponsor's telephor number 360-394-5820			
19351 8	TH AVENUE, SUITE 106	SAME	SAME					
	BO, WA 98370	POULSBO, WA 98370			2d Business code (see instructions)			
					511110			
	•	complete filing of this return/repo						
		enalties set forth in the instructions, as the electronic version of this return						
	, , , , , , , , , , , , , , , , , , , ,							
SIGN	Filed with authorized/valid ele	ectronic signature.	09/13/2011	TIMOTHY BULLOCK				
HERE			_					
	Signature of plan adminis	trator	Date	Enter name of individual s	igning as plan administrator			
SIGN								
HERE								
	Signature of employer/pla	n sponsor	Date	Enter name of individual s	igning as employer or plan sp	onsor		
OLC !								
SIGN								

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

Form 5500 (2010) v.092307.1

Enter name of individual signing as DFE

Form 5500 (2010) Page **2** 

	Plan administrator's name and address (if same as plan sponsor, enter "San	ne")	<b>3b</b> Administrator's EIN 91-1396047		
193	1 BULLOCK 351 8TH AVENUE, SUITE 106 ULSBO, WA 98370		nu	ministrator's telephone mber 0-394-5820	
_				Ab co.	
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:	n/report filed for this plan, enter the name, EIN	and	4b EIN	
а	Sponsor's name			4c PN	
5	Total number of participants at the beginning of the plan year		5	430	
6	Number of participants as of the end of the plan year (welfare plans complete	e only lines <b>6a, 6b, 6c,</b> and <b>6d</b> ).			
а	Active participants		6a	379	
h	Retired or separated participants receiving benefits		6b	0	
b	Retired of separated participants receiving benefits		OD	0	
С	Other retired or separated participants entitled to future benefits		6c	0	
d	Subtotal. Add lines <b>6a</b> , <b>6b</b> , and <b>6c</b>		6d	379	
_			C-		
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefits	6e		
f	Total. Add lines 6d and 6e		6f	379	
g	Number of participants with account balances as of the end of the plan year				
	complete this item)		6g		
h	Number of participants that terminated employment during the plan year with less than 100% vested		6h		
7	Enter the total number of employers obligated to contribute to the plan (only		7		
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from the List of Plan Characteristic Codes	s in the i	nstructions:	
	f the plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E 4H				
9a	Plan funding arrangement (check all that apply)  (1) Insurance	9b Plan benefit arrangement (check all that (1) Insurance	at apply)		
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)	insuranc	e contracts	
	(3) Trust	(3) Trust			
	(4) Keneral assets of the sponsor	(4) X General assets of the sp	onsor		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, where indicated, enter the numb	oer attac	hed. (See instructions)	
а	Pension Schedules	b General Schedules			
	R (Retirement Plan Information)	(1) H (Financial Inform	,	O II DI )	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(2) I (Financial Inform  (3) A (Insurance Inform		Small Plan)	
	actuary	(3) A (Insurance Infor C (Service Provide	,	nation)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) D (DFE/Participati		,	
	Information) - signed by the plan actuary	(6) G (Financial Trans	•	•	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Co	orporation	▶ 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 20	10 or fiscal plar	n year beginning 03/01/2010	and .	ending 02	2/28/2011		
A Name of plan SOUND PUBLISHING, IN	NC. BENEFIT P	PLAN		ee-digit n number (Pl	N) <b>•</b>	501	
C Plan sponsor's name a SOUND PUBLISHING, IN		e 2a of Form 5500.		oyer Identific 396047	cation Number (	EIN)	
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca		F CANADA		_			
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		Policy or co	ontract year	
(b) EIN	code	identification number	policy or contract year	(f)	From	<b>(g)</b> To	
38-1082080	80802	011981	379	03/01/20	)10	02/28/2011	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. List in item	3 the agents	, brokers, and c	other persons in	
(a) Total a	amount of com		(b) -	otal amount	of fees paid		
		2996				0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all persons).				
		and address of the agent, broker, of		sions or fees	were paid		
BROWN & BROWN OF V		. INC. 1301 F	FIFTH AVENUE, SUITE 3701 FLE, WA 98101		·		
(b) Amount of sales ar	nd base	Fees	s and other commissions paid				
commissions pa	id	(c) Amount	(d) Purpo	(d) Purpose			
	1498					3	
	(a) Name a	and address of the agent, broker, o	or other person to whom commis	sions or fees	were paid		
KRISTIN MANWARING I	NSURANCE A		OX 2107 TOWNSEND, WA 98368				
(b) Amount of calca as	ad bass	Fees	s and other commissions paid				
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	1498					3	
For Panerwork Reduction	n Act Notice a	and OMB Control Numbers, see	the instructions for Form 550	)	Sch	edule A (Form 5500) 2010	

Schedule A (Form 5500)	2010	Page <b>2-</b>		
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid	
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid	
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	me and address of the agent, broke	er or other person to whom	commissions or fees were paid	
(a) 110	and and address of the agent, prone	w, or other percent to whem	commissions of 1000 were paid	
		Fees and other commission	an noid	
(b) Amount of sales and base commissions paid	(c) Amount	rees and other commission	(d) Purpose	(e) Organization code
	(o) runount		(a) i dipoco	
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
	• •			
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns 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 individual this report.	idual contracts with	·	unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
5 (	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (	Cont	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			
		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 he	re 🕨 🗌	
7 (	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а		ite participation guar		
		(3) guaranteed investment (4) other			
		(e) Sagramood invocations (e) Sagramood invocations			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year	. 7c(1)	1 2	
		(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)		
		<b>)</b>			
		(6) Total additions		7c(6)	
	٩.	(6)Total additions			
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			
			7e(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier	- (0)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. / 5(4)		
		•			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )		7f	

Page	4

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

Part III

**Welfare Benefit Contract Information** 

		information may be combined for reporting put the entire group of such individual contracts w						cts cover individual employees,
<b>8</b> E	Benef	it and contract type (check all applicable boxes)		•				
;	а∏	Health (other than dental or vision)	b	Dental	С	Vision		<b>d</b> X Life insurance
	е ⊣	Temporary disability (accident and sickness)	f	Long-term disabilit	ty <b>g</b>	Suppleme	ental unemployment	h Prescription drug
i	iΗ	Stop loss (large deductible)	ιĖ	HMO contract	, s k	<b>=</b> ··		I Indemnity contract
	~⊟		י ר	Third contract			idot	
•	m	Other (specify)						
9 F	xperi	ence-rated contracts:						
		remiums: (1) Amount received			9a(1)			
		2) Increase (decrease) in amount due but unpaid			9a(2)			
	•	B) Increase (decrease) in unearned premium res			9a(3)			
		4) Earned ((1) + (2) - (3))		•			9a(4)	
	b E	Benefit charges (1) Claims paid			9b(1)			
	(2	2) Increase (decrease) in claim reserves			9b(2)			
	(3	3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )					9b(3)	
	(4	4) Claims charged					9b(4)	
	C F	Remainder of premium: (1) Retention charges (or	n an	accrual basis)		T		
		(A) Commissions			9c(1)(A)			
		(B) Administrative service or other fees			9c(1)(B)			<u></u>
		(C) Other specific acquisition costs			9c(1)(C)			
		(D) Other expenses			9c(1)(D)			
		(E) Taxes			9c(1)(E) 9c(1)(F)			
		(F) Charges for risks or other contingencies			A (4)(A)			
		(G) Other retention charges(H) Total retention					9c(1)(H	1)
	ľ	Dividends or retroactive rate refunds. (These		_	_			·/
		Status of policyholder reserves at end of year: (1)			<u></u>			
		2) Claim reserves		·				
	,	3) Other reserves						
	,	Dividends or retroactive rate refunds due. (Do no						
10		experience-rated contracts:			-( ) /			
		Fotal premiums or subscription charges paid to c	arrie	r			10a	5240
		f the carrier, service, or other organization incurr						
		etention of the contract or policy, other than repo	orted	in Part I, item 2 abov	ve, report a	mount	10b	
	Spe	cify nature of costs						
Da	rt IV	Provision of Information						
							□ v	X No
		he insurance company fail to provide any inform			ete Schedu	le A?	. Yes	X No
12	If the	e answer to line 11 is "Yes," specify the informati	on n	ot provided. 🕨				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

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

#### File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

	nurought to EDICA continu (102/a)/2)					m is Open to Public Inspection
For calendar plan year 20	10 or fiscal pla	and en				
A Name of plan SOUND PUBLISHING, IN	IC. BENEFIT I	PLAN	E	3 Three plan r	-digit number (PN)	501
C Plan sponsor's name a SOUND PUBLISHING, IN		ne 2a of Form 5500.	1	91-1396	ver Identification Number ( 6047	EIN)
		ning Insurance Contract Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance ca		ANY				
	1		(-) A		Dalianas	
(b) EIN	(c) NAIC	(d) Contract or identification number	(e) Approximate num persons covered at e		•	ontract year
. ,	code	identification number	policy or contract y	ear	(f) From	<b>(g)</b> To
41-0451140	67105	66958-0	337		03/01/2010	02/28/2011
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. List	in item 3	the agents, brokers, and o	other persons in
(a) Total a	amount of com	missions paid		<b>(b)</b> Tot	al amount of fees paid	
		0				0
3 Persons receiving com		fees. (Complete as many entrie				
	(a) Name	and address of the agent, broke	er, or other person to whom	commission	ons or fees were paid	
(b) Amount of sales ar	nd hasa	F	ees and other commissions	paid		
commissions pa		(c) Amount	(d) Purpose			(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to whom	commissio	ons or fees were naid	
	(a) Name	and address of the agent, broke	ir, or other person to whom	501111113310	ons or rees were paid	
(b) Amount of sales ar	nd base	F	ees and other commissions	paid		
commissions pa		(c) Amount	(d)	Purpose Purpose	(e) Organization code	

Schedule A (Form 5500)	2010	Page <b>2-</b>		
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid	
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid	
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	me and address of the agent, broke	er or other person to whom	commissions or fees were paid	
(a) 110	and and address of the agent, prone	w, or other percent to whem	commissions of 1000 were paid	
		Fees and other commission	an noid	
(b) Amount of sales and base commissions paid	(c) Amount	rees and other commission	(d) Purpose	(e) Organization code
	(o) runount		(a) i dipoco	
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
	• •			
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns 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 individual this report.	idual contracts with	·	unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
5 (	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (	Cont	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			
		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 he	re 🕨 🗌	
7 (	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а		ite participation guar		
		(3) guaranteed investment (4) other			
		(e) Sagramood invocations (e) Sagramood invocations			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year	. 7c(1)	1 2	
		(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)		
		<b>)</b>			
		(6) Total additions		7c(6)	
	٩.	(6)Total additions			
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			
			7e(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier	- (0)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. / 5(4)		
		•			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )		7f	

Page	4

ŀ	art III	weitare Benefit Contract Informa						
		If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	urposes if such contracts	are experience	ce-rated as a unit. W	here contrac		
5	Benef	it and contract type (check all applicable boxes)	-			•		_
`	_	Health (other than dental or vision)	. —	٦	l Vision		d 🗆 Life incurance	
	a ∐	· ·	<b>b</b> Dental	_	Vision		d Life insurance	
	e 📙	Temporary disability (accident and sickness)	f Long-term disabili	ity <b>g</b>	Supplemental une	mployment	<b>h</b> Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)						
ć	<b>E</b> xperi	ience-rated contracts:						
	<b>a</b> Pr	remiums: (1) Amount received		. 9a(1)				
	(2	2) Increase (decrease) in amount due but unpai	d	. 9a(2)				
	,	3) Increase (decrease) in unearned premium re						
	(4	4) Earned ( <b>(1) + (2) - (3)</b> )				9a(4)		
	b E	Benefit charges (1) Claims paid		. 9b(1)				
	(2	2) Increase (decrease) in claim reserves		. 9b(2)				
	(3	3) Incurred claims (add (1) and (2))				9b(3)		
	(4	4) Claims charged				9b(4)		
	<b>C</b> F	Remainder of premium: (1) Retention charges (	on an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)	)	
	(	2) Dividends or retroactive rate refunds. (These	e amounts were paid in	n cash, or	credited.)	9c(2)		
		Status of policyholder reserves at end of year: (		<u></u>				_
		2) Claim reserves						_
	,	3) Other reserves				9d(3)		_
	,	Dividends or retroactive rate refunds due. (Do r						_
1		experience-rated contracts:		( ) /				
		Fotal premiums or subscription charges paid to	carrier			10a	24751	8
		f the carrier, service, or other organization incur	, ,			10b		
		cify nature of costs	oneu iirr aiti, itelli 2 dD0	ve, report am	ourt			_
	Spe	city flature of costs V						
F	Part IV	Provision of Information						
		the insurance company fail to provide any inforr	nation necessary to comp	lete Schedule	Δ2 Γ	Yes	X No	
		and modification company fall to provide any lillon	nation necessary to comp	ioto oci ledule	/ / /		LI	

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 1 011	m is Open to Public Inspection	
For calendar plan year 2010 or fiscal plan year beginning 03/01/2010 and ending 02/28/2011						
A Name of plan SOUND PUBLISHING, IN	IC. BENEFIT P	LAN		e-digit number (PN)	501	
C Plan sponsor's name as shown on line 2a of Form 5500.  SOUND PUBLISHING, INC.  D Employer Identification Number (EIN) 91-1396047						
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	rrier					
	(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	<b>(g)</b> To	
91-6056925	47317	12077894	341	03/01/2010	02/28/2011	
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) Total a	amount of comn		<b>(b)</b> To	otal amount of fees paid		
		777			0	
3 Persons receiving com	missions and fe	es. (Complete as many entries a	is needed to report all persons).			
			or other person to whom commiss OX 2107	ions or fees were paid		
KRISTIN MANWARING II	NSURANCE AS		TOWNSEND, WA 98368			
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions pa	<u> </u>	(c) Amount	(d) Purpose		(e) Organization code	
724					3	
	(a) Name a		or other person to whom commiss	ions or fees were paid		
BROWN & BROWN OF WASHINGTON, INC.  1301 FIFTH AVENUE, SUITE 3701 SEATTLE, WA 98101						
(b) Amount of sales ar	nd hase	Fees	and other commissions paid			
commissions pai		(c) Amount	(d) Purpose	e	(e) Organization code	
	53				3	
For Panerwork Reduction	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form 5500	Sch	 edule A (Form 5500) 2010	

Schedule A (Form 5500)	2010	Page <b>2-</b>					
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid				
(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 commission		(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid				
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid				
(b) Amount of sales and base		Fees and other commission		(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
(a) Na	me and address of the agent, broke	er or other person to whom	commissions or fees were paid				
(a) 110	and and address of the agent, prone	w, or other percent to whem	commissions of 1000 were paid				
		Fees and other commission	an noid				
(b) Amount of sales and base commissions paid	(c) Amount	rees and other commission	(d) Purpose	(e) Organization code			
	(o) runount		(a) i dipoco				
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid				
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
	• •						
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid				
(b) Amount of sales and base		Fees and other commission	ns 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 individual this report.	idual contracts with	·	unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
5 (	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (	Cont	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			
		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 he	re 🕨 🗌	
7 (	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а		ite participation guar		
		(3) guaranteed investment (4) other			
		(e) Sagramood invocations (e) Sagramood invocations			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year	. 7c(1)	1 2	
		(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)		
		<b>)</b>			
		(6) Total additions		7c(6)	
	٩.	(6)Total additions			
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			
			7e(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier	- (0)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. / 5(4)		
		•			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )		7f	

Page	4
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Part	Part III Weitare 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							
		If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	ourposes if such contract	cts are experienc	ce-rated as a unit. W	here contrac		
<b>8</b> B	enefit	and contract type (check all applicable boxes)	(;					
а	_	Health (other than dental or vision)	<b>b</b> Dental	c×	Vision		<b>d</b> Life insurance	
			f Long-term disa	<u> </u>	Supplemental une	mploymont	h Prescription drug	
е		Temporary disability (accident and sickness)	님	· · · · · · · · · · · · · · · · · · ·		прюуттети		
		Stop loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity contract	
n	n ∐ (	Other (specify)						
	•	ence-rated contracts:					_	
а		emiums: (1) Amount received					_	
	` '	) Increase (decrease) in amount due but unpai					4	
	` '	) Increase (decrease) in unearned premium res				00(4)		
		) Earned ((1) + (2) - (3))				9a(4)		
		enefit charges (1) Claims paid		21 (2)				
	` '	) Increase (decrease) in claim reserves				9b(3)		
	` '	) Claims charged						
	` '	emainder of premium: (1) Retention charges (				<u>JD(4)</u>		
`		(A) Commissions	,	9c(1)(A)				
		(B) Administrative service or other fees		2 (1)(7)				
		(C) Other specific acquisition costs					7	
		(D) Other expenses						
		(E) Taxes		0. (4)(5)				
		(F) Charges for risks or other contingencies.		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)	)	
	(2	2) Dividends or retroactive rate refunds. (These	e amounts were pai	d in cash, or	credited.)	9c(2)		
(	d St	tatus of policyholder reserves at end of year: (	1) Amount held to provi	de benefits after	retirement	9d(1)		
	(2	) Claim reserves				9d(2)		
	(3	) Other reserves				9d(3)		
		ividends or retroactive rate refunds due. (Do n	not include amount ente	ered in <b>c(2)</b> .)		9e		
10	None	xperience-rated contracts:						
•		otal premiums or subscription charges paid to				10a		32834
	re	the carrier, service, or other organization incur tention of the contract or policy, other than rep				10b		
	Spec	ify nature of costs						
Part	: IV	Provision of Information						
11	Did th	ne insurance company fail to provide any inform	mation necessary to con	mplete Schedule	A?	Yes	X No	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation  Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				m is Open to Public Inspection			
For calendar plan year 20	For calendar plan year 2010 or fiscal plan year beginning 03/01/2010				ding 02	/28/2011	
A Name of plan SOUND PUBLISHING, INC. BENEFIT PLAN				B Three plan	e-digit number (Pl	N) •	501
C Plan sponsor's name a SOUND PUBLISHING, IN		e 2a of Form 5500.		<b>D</b> Emplo 91-139		cation Number (	EIN)
		ning Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca SUN LIFE ASSURANCE		F CANADA					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered at			Policy or co	· ·
(b) Env	code	identification number	policy or contract		(f)	From	<b>(g)</b> To
38-1082080	80802	011981	37	<b>'</b> 9	03/01/20	)10	02/28/2011
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. Li	st in item 3	the agents	, brokers, and c	ther persons in
(a) Total a	amount of com			<b>(b)</b> To	tal amount	of fees paid	
		3588					0
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all p	persons).			
-		and address of the agent, broker,			ons or fees	were paid	
BROWN & BROWN OF V	VASHINGTON		FIFTH AVENUE, SUITE TLE, WA 98101	3701			
(b) Amount of sales ar	nd base	Fees	s and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose		(e) Organization code	
1794							3
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
KRISTIN MANWARING INSURANCE ASSOC.  P.O. BOX 2107 PORT TOWNSEND, WA 98368							
(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount		(d) Purpose	)		(e) Organization code
	1794						3
For Paperwork Reductio	n Act Notice a	and OMB Control Numbers, see	the instructions for F	orm 5500.		Scho	edule A (Form 5500) 2010

Schedule A (Form 5500)	2010	Page <b>2-</b>					
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid				
(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 commission		(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid				
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid				
(b) Amount of sales and base		Fees and other commission		(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
(a) Na	me and address of the agent, broke	er or other person to whom	commissions or fees were paid				
(a) 110	and and address of the agent, prone	w, or other percent to whem	commissions of 1000 were paid				
		Fees and other commission	an noid				
(b) Amount of sales and base commissions paid	(c) Amount	rees and other commission	(d) Purpose	(e) Organization code			
	(o) runount		(a) i dipoco				
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid				
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization			
commissions paid	(c) Amount		(d) Purpose	code			
	• •						
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid				
(b) Amount of sales and base		Fees and other commission	ns 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 individual this report.	idual contracts with	·	unit for purposes of
		ent value of plan's interest under this contract in the general account at year			
5 (	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 (	Cont	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			
		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 he	re 🕨 🗌	
7 (	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а		ite participation guar		
		(3) guaranteed investment (4) other			
		(e) Sagramood invocations (e) Sagramood invocations			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year	. 7c(1)	1 2	
		(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)		
		<b>)</b>			
		(6) Total additions		7c(6)	
	٩.	(6)Total additions			
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			
			7e(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier	- (0)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. / 5(4)		
		•			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )		7f	

Page	4

Pa	rt II	I 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 surposes if such contracts a	are experier	nce-rated as a unit. V	Vhere contrac	
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		d Life insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term disability	y <b>g</b>		mployment	h Prescription drug
	: [	Stop loss (large deductible)	j HMO contract	k	=	mploymont	
	' L		I HIMO contract	N.	PPO contract		I Indemnity contract
	m	Other (specify)					
<u> </u>	Evn	erience-rated contracts:					
9		Premiums: (1) Amount received	Г	9a(1)			
	u	(2) Increase (decrease) in amount due but unpaid		9a(1)			
		(3) Increase (decrease) in unearned premium res	T T	9a(3)			
		(4) Earned ((1) + (2) - (3))	_			9a(4)	
	b	Benefit charges (1) Claims paid	Г	9b(1)		Ja(+)	
	D	(2) Increase (decrease) in claim reserves	-	9b(2)			
		(3) Incurred claims (add (1) and (2))	_			9b(3)	
		(4) Claims charged				9b(4)	<del> </del>
	С	Remainder of premium: (1) Retention charges (o			•••••	<u>35(4)</u>	
	Ü	(A) Commissions	The state of the s	9c(1)(A)			
		(B) Administrative service or other fees	F	9c(1)(B)			
		(C) Other specific acquisition costs	T T	9c(1)(C)			
		(D) Other expenses	i i i i i i i i i i i i i i i i i i i	9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies	H H	9c(1)(F)			
		(G) Other retention charges	-	9c(1)(G)			
		(H) Total retention	_			9c(1)(H	)
		(2) Dividends or retroactive rate refunds. (These	_	-			
	d	Status of policyholder reserves at end of year: (1	_				
	_	(2) Claim reserves	•				
		(3) Other reserves					
	е	Dividends or retroactive rate refunds due. (Do no					
10	No	nexperience-rated contracts:		(-).,			
	а	Total premiums or subscription charges paid to c	arrier			10a	31762
	b	If the carrier, service, or other organization incurr					
		retention of the contract or policy, other than repo				10b	
	Specify nature of costs •						
Pa	rt I	/ Provision of Information					
		I the insurance company fail to provide any inform	ation necessary to comple	ete Schedu	le A?	Yes	No

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

2010

This Form is Open to Public Inspection.

For calendar plan year 2010 or fiscal plan year beginning 03/01/2010	and ending 02/28/2011	
A Name of plan SOUND PUBLISHING, INC. BENEFIT PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500	<b>D</b> Employer Identification Number	er (EIN)
SOUND PUBLISHING, INC.	91-1396047	- (
Dout I Compiled Duravidou Information (and instructions)		
Part I   Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the information or more in total compensation (i.e., money or anything else of monetary value) in connectic plan during the plan year. If a person received <b>only</b> eligible indirect compensation for which answer line 1 but are not required to include that person when completing the remainder of	on with services rendered to the plan on the plan received the required discl	or the person's position with the
1 Information on Persons Receiving Only Eligible Indirect Compensa	tion	
<b>a</b> Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of		
indirect compensation for which the plan received the required disclosures (see instructions	s for definitions and conditions)	Yes X No
<b>b</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 in	•	vice providers who
(b) Enter name and EIN or address of person who provided you di	sclosures on eligible indirect compen	sation
(b) Enter name and EIN or address of person who provided you d	isclosure on eligible indirect compens	sation
(b) Enter name and EIN or address of person who provided you di	sclosures on eligible indirect compen	sation
(b) Enter name and Enver address of person time promote you an		outon .
(b) Enter name and EIN or address of person who provided you di	sclosures on eligible indirect compen-	sation

	Schedule C (Form 5500) 2010	Page <b>2-</b>	
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
1	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	irect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	irect compensation

answered	d "yes" to line 1a above	e, complete as many e	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in to	otal compensation
			a) Enter name and EIN or	address (see instructions)		
FIRST CH	OICE HEALTH ADMIN		a) Litter hame and Lift of	address (see instructions)		
91-127276	6					
(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?
12	NONE	126651	Yes No X	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
91-127276 (b) Service Code(s)	(c)  Relationship to employer, employee	(d) Enter direct compensation paid	(e) Did service provider receive indirect	(f) Did indirect compensation include eligible indirect	(g) Enter total indirect compensation received by	(h) Did the service provider give you a
. ,	organization, or person known to be a party-in-interest	by the plan. If none, enter -0	compensation? (sources other than plan or plan sponsor)	compensation, for which the plan received the required disclosures?	service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or
13	NONE	13983	Yes No 🖺	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
KRISTIN M 20-465076	IANWARING INSURA 4	NCE ASSOC.				
(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?	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?
22 53	NONE	18099	Yes ☐ No ☒	Yes No N		Yes No No

	Schedule C (Form 550	00) 2010		Page <b>4-</b>		
		(	a) Enter name and EIN or	address (see instructions)		
BROWN &	BROWN OF WASHIN	IGTON, INC.				
91-037894	0					
(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?
2 53	NONE	18099	Yes No X	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or	(d) Enter direct compensation paid by the plan. If none,	(e) Did service provider receive indirect compensation? (sources	(f) Did indirect compensation include eligible indirect compensation, for which the	(g) Enter total indirect compensation received by service provider excluding	(h) Did the service provider give you a formula instead of
	person known to be a party-in-interest	enter -0	other than plan or plan sponsor)	plan received the required disclosures?	eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	an amount or estimated amount?
			Yes No	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		

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 compen or provides contract administrator, consulting, custodial, investment advisory, investment may questions for (a) each source from whom the service provider received \$1,000 or more in increase provider gave you a formula used to determine the indirect compensation instead of an amomany entries as needed to report the required information for each source.	anagement, broker, or recordkeepindirect compensation and (b) each so	g services, answer the following burce for whom the service
(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 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 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 the service provider's eligibility the indirect compensation.

Page **5-**

Schedule C (Form 5500) 2010

Page 6-	1
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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		
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Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)  (complete as many entries as needed)					
а	Name:	·	<b>b</b> EIN:		
С	Positio	n:			
d	Addres	s:	e Telephone:		
Ex	planatior	:			
a	Name:		<b>b</b> EIN:		
C	Positio	n:			
d	Addres		e Telephone:		
Fx	planatior	<u> </u>			
_^	<sub>-</sub>	<del>.</del>			
а	Name:		<b>b</b> EIN:		
c	Positio	n:			
d	Addres		e Telephone:		
			•		
Ex	planatior	:			
а	Name:		<b>b</b> EIN;		
С	Positio	n:			
d	Addres		e Telephone:		
Ex	planatior	:			
<u>a</u>	Name:		b EIN;		
С	Positio				
d	Addres	s:	e Telephone:		
Ex	Explanation:				