Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

HERE

Signature of DFE

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2010

					Inspection	JUIC
Part I		tification Information				
For cale	ndar plan year 2010 or fiscal p	plan year beginning 04/01/2010		and ending 03/31/2	2011	
A This	return/report is for:	a multiemployer plan;	a multip	ole-employer plan; or		
		X a single-employer plan;	a DFE	(specify)		
		<u>_</u>	_			
B This	return/report is:	the first return/report;	the fina	I return/report;		
		X an amended return/repor	t; a short	plan year return/report (less th	nan 12 months).	
C If the	plan is a collectively-bargaine	ed plan, check here				
D Chec	k box if filing under:	Form 5558;	automa	tic extension;	the DFVC program;	
		special extension (enter	<u> </u>			
Part	II Rasic Plan Inform	nation—enter all requested info	. ,			
	ne of plan	Tation Chici all requested line	mation		1b Three-digit plan	501
	C FRUIT COMPANY, LLC				number (PN) ▶	301
					1c Effective date of pla 07/01/1998	an
		s (employer, if for a single-employ	rer plan)		2b Employer Identifica	ition
	ress should include room or s	suite no.)			Number (EIN)	
OLYMPI	C FRUIT COMPANY, LLC				91-1646105	
					2c Sponsor's telephone number	
2450 BE	AUDRY ROAD	24E0 D	EALIDBY BOAD		509-457-2075	
	, WA 98936		EAUDRY ROAD E, WA 98936		2d Business code (see	Э
			instructions)			
		complete filing of this return/re				
		enalties set forth in the instruction as the electronic version of this re				
SIGN HERE	Filed with incorrect/unrecogni	ized electronic signature.	11/02/2011	PAUL KOCH		
	Signature of plan adminis	trator	Date	Enter name of individual si	igning as plan administrator	
SIGN HERE						
TILICE	Signature of employer/pla	n sponsor	Date	Enter name of individual si	igning as employer or plan sp	onsor
SIGN						

Date

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 "Sam YMPIC FRUIT COMPANY, LLC	ne")		Iministrator's EIN 1646105
	50 BEAUDRY ROAD XEE, WA 98936		nu	Iministrator's telephone Imber 9-457-2075
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	l and	4b EIN
а	Sponsor's name			4c PN
5	Total number of participants at the beginning of the plan year		5	71
6	Number of participants as of the end of the plan year (welfare plans complete	e only lines 6a, 6b, 6c, and 6d).		
а	Active participants		. 6a	107
a				
b	Retired or separated participants receiving benefits		. 6b	0
С	Other retired or separated participants entitled to future benefits		. 6c	0
d	Subtotal. Add lines 6a, 6b, and 6c		. 6d	107
е	Deceased participants whose beneficiaries are receiving or are entitled to re-	ceive benefits	. 6e	0
f	Total. Add lines 6d and 6e		. 6f	
g	Number of participants with account balances as of the end of the plan year complete this item)	•	. 6g	0
h	Number of participants that terminated employment during the plan year with less than 100% vested		6h	0
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 Code	s in the i	instructions:
	f the plan provides welfare benefits, enter the applicable welfare feature codes 4A 4B 4D 4E 4Q			
9a	Plan funding arrangement (check all that apply) (1)	9b Plan benefit arrangement (check all the (1) Insurance	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)	insurano	ce contracts
	(3) Trust (4) General assets of the sponsor	(3) Trust (4) X General assets of the s	nonsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a			ched. (See instructions)
а	Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) H (Financial Inform (2) I (Financial Inform (3) X 3 A (Insurance Inform (4) C (Service Provid) (5) D (DFE/Participat) (6) G (Financial Trans	nation – rmation) er Inform ing Plan	nation) Information)
	Information) - signed by the plan actuary	(6) G (Financial Trans	saction S	Schedules)

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2010

r ension benefit duaranty of	Siporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			orm is Open to Public Inspection	
For calendar plan year 20	10 or fiscal plan	n year beginning 04/01/2010	and er	nding 03/31/2011		
A Name of plan OLYMPIC FRUIT COMP	ANY, LLC			e-digit number (PN)	501	
C Plan sponsor's name a OLYMPIC FRUIT COMP		e 2a of Form 5500.	D Emplo 91-164	oyer Identification Number	er (EIN)	
on a separat		ning Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	Policy or	contract year	
(b) LIN	code	identification number	policy or contract year	(f) From	(g) To	
36-0792925	61425	JY586	111 04/01/2010		03/31/2011	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	commissions paid. List in item 3	the agents, brokers, an	d other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						
	18270					
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all persons).			
		and address of the agent, broker, o		ions or fees were paid		
CONOVER INSURANCE		PO BC	X 10088 A, WA 98909	·		
(b) Amount of sales a	nd hase	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose	(e) Organization code		
	18270				3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
	(a) Hamo	and address of the agent, protor, c	v cater person to whom common	iono en rece were para		
(b) Amount of sales and base Fees and other commissions paid						
commissions pa		(c) Amount	(d) Purpose	(e) Organization code		
	A 4 NI 41					

Schedule A (Form 5500)	2010	Page 2-		
(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	
(a) 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
	• •			
(a) 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)		
)			
		(6) Total additions		7c(6)	
	٩.	(6)Total additions			
		Total of balance and additions (add b and c(6))			
			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 e(5) from d)		7f	

Page	4

P	art II	Welfare Benefit Contract Information If more than one contract covers the same grainformation may be combined for reporting puthe entire group of such individual contracts we	oup of employees of the sposes if such contracts	are experier	nce-rated as a unit. W	here contrac	
8	Ben	efit and contract type (check all applicable boxes)	_				_
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental uner	mployment	h Prescription drug
	i [Stop loss (large deductible)	j HMO contract	k	PPO contract		Indemnity contract
	m	Other (specify)	<i>,</i> ¬	!	_		
	···· L	Girlor (opcomy)					
9	Expe	erience-rated contracts:					
_		Premiums: (1) Amount received		9a(1)			7
		(2) Increase (decrease) in amount due but unpaid					
		(3) Increase (decrease) in unearned premium res		9a(3)			7
		(4) Earned ((1) + (2) - (3))	•			9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		/->			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)		T	
		(H) Total retention	_)
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	··· 9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits afte	er retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	d in c(2) .)		9e	
1() No	nexperience-rated contracts:					400704
	a	Total premiums or subscription charges paid to ca				<u>10a</u>	182701
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo				10b	
	Sr	pecify nature of costs	itted iii i ait i, iteiii 2 abo	ve, report ar	110u11t		
	Op	really flattare of cools 7					
P	art I	V Provision of Information					
				-4- O-1- 1	Г. А.	Yes	No
- 1	ı Did	the insurance company fail to provide any inform	ation necessary to compl	ete Schedu	le A?	169	110

SCHEDULE A (Form 5500)

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

2010

			- FDICA continu 102(a)(2)			n is Open to Public Inspection	
For calendar plan year 2010 o	or fiscal plar	n year beginning 04/01/2010	0	and er	nding 03	/31/2011	
A Name of plan OLYMPIC FRUIT COMPANY	Y, LLC				e-digit number (PI	v) •	501
C Plan sponsor's name as s OLYMPIC FRUIT COMPANY		e 2a of Form 5500.		D Employer Identification Number (EIN) 91-1646105			
		ning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance carrie UNION SECURITY INSURAL (b) EIN		(d) Contract or	(e) Approximate no			Policy or co	ntract year
(D) EIN	code	identification number	•	persons covered at end of policy or contract year		From	(g) To
81-0170040 70	0408	5412450	10	08	01/01/20	10	12/31/2010
2 Insurance fee and commis descending order of the am		ation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents	, brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving commis	esions and f	ees. (Complete as many entrie		nercone)			0
J Fersons receiving commis		and address of the agent, broke			one or fees	were paid	
CONOVER INSURANCE INC		PO	BOX 10088 KIMA, WA 98909	11 00111111301	011000	were para	
(b) Amount of sales and b	226	F	ees and other commission	ns paid			
commissions paid	Juse	(c) Amount			Purpose		(e) Organization code
	2343						3
	(a) Name a	and address of the agent, broke	er, or other person to who	m commissi	ons or fees	were paid	
	(4)	aga., 2.3	., s. c			were paire	
(b) Amount of sales and b	oase		ees and other commission				
commissions paid		(c) Amount		(d) Purpose	9		(e) Organization code

Schedule A (Form 5500)	2010	Page 2-		
(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	
(a) 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
	• •			
(a) 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)		
)			
		(6) Total additions		7c(6)	
	٩.	(6)Total additions			
		Total of balance and additions (add b and c(6))			
			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 e(5) from d)		7f	

Page	4

Schedule A (Form	เ ออบบ) ZUTU
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a Health (o e Tempora i Stop loss m Other (sp 9 Experience-rate a Premiums: ((2) Increase (3) Increase (4) Earned b Benefit cha (2) Increase (3) Incurrec (4) Claims (6) Cr (B) Adr (C) Oth (D) Oth	(1) Amount received	b Dental f Long-term j HMO cont	9a(1) 9a(2) 9a(3) 9b(1) 9b(2)	PPO contract	9a(4)	d \(\text{Life insurance} \) h \(\text{Prescription drug} \) I \(\text{Indemnity contract} \)				
e Tempora i Stop loss m Other (sp Premiums: ((2) Increase (3) Increase (4) Earned b Benefit cha (2) Increase (3) Incurrec (4) Claims (C Remainder (A) Cor (B) Adr (C) Oth (D) Oth	ary disability (accident and sickness) s (large deductible) pecify) AD & D ad contracts: (1) Amount received	f Long-term j HMO cont	9a(1) 9a(2) 9a(3) 9b(1) 9b(2)	Supplemental PPO contract	9a(4)	h Prescription drug				
i Stop loss m Other (sp 9 Experience-rater a Premiums: ((2) Increase (3) Increase (4) Earned b Benefit cha (2) Increase (3) Incurrec (4) Claims (C Remainder (A) Cor (B) Adr (C) Oth (D) Oth	s (large deductible) pecify) AD & D ad contracts: (1) Amount received	j HMO cont	9a(1) 9a(2) 9a(3) 9b(1) 9b(2)	PPO contract	9a(4)					
m Other (sp 9 Experience-rate a Premiums: ((2) Increase (3) Increase (4) Earned b Benefit cha (2) Increase (3) Incurred (4) Claims ((4) Claims ((5) Adr (6) Oth (D) Oth	d contracts: (1) Amount received	dservesorveson an accrual basi	9a(1) 9a(2) 9a(3) 9b(1) 9b(2)		9a(4)	I Indemnity contract				
9 Experience-rater a Premiums: ((2) Increase (3) Increase (4) Earned b Benefit cha (2) Increase (3) Incurred (4) Claims (C Remainder (A) Cor (B) Adr (C) Oth (D) Oth	d contracts: (1) Amount received	dserveserves	9a(2) 9a(3) 9b(1) 9b(2)		9b(3)					
a Premiums: ((2) Increase (3) Increase (4) Earned b Benefit cha (2) Increase (3) Incurred (4) Claims of Remainder (A) Cor (B) Adr (C) Oth (D) Oth	(1) Amount received	dserveserves	9a(2) 9a(3) 9b(1) 9b(2)		9b(3)					
(2) Increase (3) Increase (4) Earned b Benefit cha (2) Increase (3) Incurred (4) Claims (6) C Remainder (A) Cor (B) Adr (C) Oth (D) Oth	e (decrease) in amount due but unpaide (decrease) in unearned premium res ((1) + (2) - (3))	dserveserves	9a(2) 9a(3) 9b(1) 9b(2)		9b(3)					
(3) Increase (4) Earned b Benefit cha (2) Increase (3) Incurred (4) Claims of Remainder (A) Cor (B) Adr (C) Oth (D) Oth	e (decrease) in unearned premium res ((1) + (2) - (3))	on an accrual basi	9a(3) 9b(1) 9b(2)		9b(3)					
(4) Earned b Benefit cha (2) Increase (3) Incurred (4) Claims of c Remainder (A) Cor (B) Adr (C) Oth (D) Oth	((1) + (2) - (3))	n an accrual basi	9b(1) 9b(2)		9b(3)					
b Benefit cha (2) Increase (3) Incurred (4) Claims of Remainder (A) Cor (B) Adr (C) Oth (D) Oth	arges (1) Claims paid	n an accrual basi	9b(1) 9b(2)		9b(3)					
(2) Increase (3) Incurred (4) Claims (6) C Remainder (A) Cor (B) Adr (C) Oth (D) Oth	e (decrease) in claim reservesd claims (add (1) and (2))	n an accrual basi	9b(2)							
(3) Incurred (4) Claims (C Remainder (A) Cor (B) Adr (C) Oth (D) Oth	d claims (add (1) and (2))charged	n an accrual basi								
(4) Claims (c) Remainder (A) Cor (B) Adr (C) Oth (D) Oth	chargedr of premium: (1) Retention charges (ommissionsministrative service or other fees	n an accrual basi								
C Remainder (A) Cor (B) Adr (C) Oth (D) Oth	r of premium: (1) Retention charges (o mmissions ministrative service or other fees	n an accrual basi			9b(4)					
(A) Cor (B) Adr (C) Oth (D) Oth	mmissionsministrative service or other fees		s)							
(B) Adr (C) Oth (D) Oth	ministrative service or other fees		0 (4)(4)							
(C) Oth (D) Oth						_				
(D) Oth	ner specific acquisition costs	(B) Administrative service or other fees 9c(1)(B) (C) Other specific acquisition costs 9c(1)(C)								
` '			_							
	ner expenses									
` ,	xes					_				
, ,	arges for risks or other contingencies		2 (1)(2)			_				
, ,	her retention charges		<u> </u>		9c(1)(H)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				
` '	tal retention					<i>)</i>				
	nds or retroactive rate refunds. (These	<u></u>	· -							
	policyholder reserves at end of year: (1									
()	eserves	· · · · ·								
` '	eserves									
	or retroactive rate refunds due. (Do no	ot include amoun	t entered in c(2) .)		9e					
10 Nonexperience					40-	42410				
	niums or subscription charges paid to c		42410							
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount										
Specify nature of costs										
Openity mature	5 61 60610 7									

Yes

No

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

Provision of Information

Part IV

SCHEDULE A (Form 5500)

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

2010

Pension Benefit Guaranty Con		pursuant to	nsurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This Form In					
For calendar plan year 201	0 or fiscal pla	an year beginning 04/01/201	0	and er	nding 03	/31/2011		
A Name of plan OLYMPIC FRUIT COMPA	NY, LLC				e-digit number (P	N) •	501	
C Plan sponsor's name at OLYMPIC FRUIT COMPA	s shown on li	ne 2a of Form 5500.		D Emplo 91-164		cation Number ((EIN)	
		ning Insurance Contrac . Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance car VISION SERVICE PLAN	rier							
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	contract year	
(b) EIN	code	identification number	persons covered a policy or contract	overed at end of contract year (f) From		From	(g) To	
91-6056925	47317	30006226		46	01/01/20)10	12/31/2010	
2 Insurance fee and communication descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents	, brokers, and o	other persons in	
(a) Total a	mount of con	nmissions paid		(b) To	tal amount	of fees paid		
3 Persons receiving comm	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			0	
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid		
CONOVER INSURANCE			BOX 10088 KIMA, WA 98909					
(b) Amount of sales an	d base	F	ees and other commission	ns paid				
commissions pai		(c) Amount	(d) Purpose			(e) Organization code		
	601						3	
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	_	
(b) Amount of sales an		F	ees and other commissio	ns paid				
commissions pai	d	(c) Amount		(d) Purpose	Э		(e) Organization code	

Schedule A (Form 5500)	2010	Page 2-					
(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							
commissions paid	(c) Amount		(d) Purpose	code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(a) 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				
(a) 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			
	• •						
(a) 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 contracts 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)		
)			
		(6) Total additions		7c(6)	
	٩.	(6)Total additions			
		Total of balance and additions (add b and c(6))			
			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 e(5) from d)		7f	

Page	4

Schedule A (Form	เ ออบบ) ZUTU
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Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) b Dental c Vision d Life insuran e Temporary disability (accident and sickness) f Long-term disability g Supplemental unemployment h Prescription i Stop loss (large deductible) j HMO contract k PPO contract I Indemnity or m Other (specify)	employees,
a	
e	ce
i	
### Dither (specify) ### Dither (specify)	-
P Experience-rated contracts: a Premiums: (1) Amount received	ontract
a Premiums: (1) Amount received	
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	
b Benefit charges (1) Claims paid (2) Increase (decrease) in claim reserves	
(2) Increase (decrease) in claim reserves	
(3) Incurred claims (add (1) and (2)) (4) Claims charged	
(4) Claims charged	
C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions	
(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)(E) (E) Taxes 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(F) (G) Other retention charges 9c(1)(G) (H) Total retention 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a	
(B) Administrative service or other fees	
(C) Other specific acquisition costs	
(D) Other expenses	
(E) Taxes	
(F) Charges for risks or other contingencies	
(G) Other retention charges	
(H) Total retention	
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement. 9d(1) (2) Claim reserves 9d(2) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e 10 Nonexperience-rated contracts: 10a	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	
(2) Claim reserves	
(3) Other reserves	
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier	
10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier	
Total premiums or subscription charges paid to carrier	
	7000
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or	7028
retention of the contract or policy, other than reported in Part I, item 2 above, report amount	
Specify nature of costs	

Yes

No

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

Provision of Information

Part IV

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

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 04/01/2010	and ending 03/31/201	1
A Name of plan OLYMPIC FRUIT COMPANY, LLC	B Three-digit plan number (PN)	501
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification N	lumber (EIN)
OLYMPIC FRUIT COMPANY, LLC	91-1646105	
Part I Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the inform or more in total compensation (i.e., money or anything else of monetary value) in coplan during the plan year. If a person received only eligible indirect compensation for answer line 1 but are not required to include that person when completing the remains	nnection with services rendered to the or which the plan received the required	plan or the person's position with the
1 Information on Persons Receiving Only Eligible Indirect Comp	ensation	
a Check "Yes" or "No" to indicate whether you are excluding a person from the remain		
indirect compensation for which the plan received the required disclosures (see instr	ructions for definitions and conditions)	Yes No
b If you answered line 1a "Yes," enter the name and EIN or address of each person perceived only eligible indirect compensation. Complete as many entries as needed to		e service providers who
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect cor	mpensation
(b) Enter name and EIN or address of person who provided	I you disclosure on eligible indirect com	npensation
		_
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect cor	mpensation
· · · · · · · · · · · · · · · · · · ·	, ,	<u>'</u>
(b) Enter name and EIN or address of person who provided	vou disclosures on eligible indirect con	npensation
(a) Like. Name and Lift of address of person who provided	, sa alcolocated of oligible marrott our	

	Schedule C (Form 5500) 2010	Page 2-	
	(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	f "yes" to line 1a above	e, complete as many e	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in to	otal compensation
		(a) Enter name and EIN or	address (see instructions)		
HEALTHC	OMP ADMINISTRATO)RS	•	,		
77-038572	9					
(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?
13 50	CONTRACT ADMIN	35155	Yes No X	Yes No		Yes No
	1	•	a) Enter name and FIN or	address (see instructions)		
91-112337((b) Service	(c) Relationship to	(d) Enter direct	(e) Did service provider	(f) Did indirect compensation	(g) Enter total indirect	(h) Did the service
Code(s)	employer, employee		receive indirect compensation? (sources other than plan or plan sponsor)	include eligible indirect compensation, for which the plan received the required disclosures?	compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	provider give you a formula instead of an amount or
22 50	BROKER	6440	Yes No No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
91-127276	OICE HLTH NTWK					
(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?
50 99	PPO VENDOR	5603	Yes No X	Yes No		Yes No

	Schedule C (Form 5500) 2010			Page 4-		
		(a) Enter name and EIN or	address (see instructions)		
		`	<u>.,</u>			
(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?
			Yes No	Yes No		Yes No No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	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	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	Enter total indirect compensation received by service provider excluding	(h) Did the service provider give you a formula instead of

other than plan or plan

sponsor)

Yes No

plan received the required

disclosures?

Yes No

person known to be

a party-in-interest

enter -0-.

eligible indirect

compensation for which you answered "Yes" to element

(f). If none, enter -0-.

an amount or

estimated amount?

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.

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Schedule C (Form 5500) 2010

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

Schedule C (Form 5500) 2010	

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