#### 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

i crisic	in benefit dualanty dorporation				This Form is Open to Public Inspection	
Part I	Annual Report Iden	ntification Information				
For caler	ndar plan year 2010 or fiscal	plan year beginning 02/01/201	10	and ending 0°	1/31/2011	
A This	eturn/report is for:	a multiemployer plan;	× a multip	le-employer plan; or		
		a single-employer plan;	a DFE (	specify)		
<b>B</b> This r	eturn/report is:	the first return/report;	the final	return/report;		
		an amended return/rep	ort; a short p	olan year return/report (I	ess than 12 months).	
<b>C</b> If the	plan is a collectively-bargaine	ed plan, check here	<del></del>			
D Chec	k box if filing under:	Form 5558;	automat	ic extension;	the DFVC program;	
2 000	Sex ii iiiiig ailaeil	special extension (ente	<u>—</u>	·		
Part	II Rasic Plan Inform	nation—enter all requested in	' '			
	ne of plan	nation—enter an requested in	omation		<b>1b</b> Three-digit plan 501	
	•	MERICA HEALTH CARE TRUST	-		number (PN) •	
					1c Effective date of plan	
					02/01/2007	
	sponsor's name and addres ress should include room or s	s (employer, if for a single-emplo	oyer plan)		<b>2b</b> Employer Identification Number (EIN)	
`	TED ASSOCIATIONS OF AM	,			20-1050245	
					2c Sponsor's telephone	
					number	
P.O. BO			148TH AVE NE		2d Business code (see	
REDMO	ND, WA 98073	REDI	DMOND, WA 98052		instructions)	
					525100	
Caution	A penalty for the late or in	complete filing of this return/i	renort will be assessed	unless reasonable ca	use is established	
		•			port, including accompanying schedules,	
	, , ,		•		nd belief, it is true, correct, and complete.	
SIGN	Filed with authorized/valid ele	ectronic signature.	11/04/2011	PATRICK A CHESTI	NUT	
HERE	Signature of plan administrator		Date	Enter name of individual signing as plan administrator		
SIGN						
HERE	Signature of employer/pla	an sponsor	Date	Enter name of individ	lual signing as employer or plan sponsor	
					9 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
SIGN						
HERE	Signature of DFE		Date	Enter name of individ	lual signing as DFE	

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

Form 5500 (2010) v.092307.1

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	Plan administrator's name and address (if same as plan sponsor, enter "San FILIATED ASSOCIATIONS OF AMERICA	ne")		ministrator's EIN 1050245
	D. BOX 775 DMOND, WA 98073			ministrator's telephone mber
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	9637
6	Number of participants as of the end of the plan year (welfare plans complet	e only lines <b>6a, 6b, 6c,</b> and <b>6d</b> ).		
а	Active participants		. 6a	8338
b	Retired or separated participants receiving benefits		6b	24
С	Other retired or separated participants entitled to future benefits		. 6c	82
d	Subtotal. Add lines 6a, 6b, and 6c		6d	8444
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefits	6e	
f	Total. Add lines <b>6d</b> and <b>6e</b>	. 6f		
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 b	If the plan provides pension benefits, enter the applicable pension feature confit the plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E			
	Plan funding arrangement (check all that apply)  (1)	9b Plan benefit arrangement (check all that (1) Insurance (2) Code section 412(e)(3) (3) Trust General assets of the sp	insurand	e contracts
10 a	Check all applicable boxes in 10a and 10b to indicate which schedules are a  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) 4 A (Insurance Inform (4) X C (Service Provide (5) D (DFE/Participati (6) G (Financial Trans	nation) nation – mation) er Inform ng Plan	Small Plan) nation) Information)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

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

Insurance companies are required to provide the information

OMB No. 1210-0110

nurought to EDICA continu 100/o\/0\					rm is Open to Public Inspection		
For calendar plan year 2010 or fiscal plan year beginning 02/01/2010 and ending 01/31/2011							
A Name of plan AFFILIATED ASSOCIATION	ONS OF AME	ERICA HEALTH CARE TRUST		ee-digit n number (PN)	501		
C Plan sponsor's name a AFFILIATED ASSOCIATION				oyer Identification Number 150245	(EIN)		
	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							
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or c	ontract year		
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To		
36-2739571	91529	666		05/01/2010	04/30/2011		
	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 amount of commissions paid (b) Total amount of fees paid							
		0			0		
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all persons).				
	(a) Name	and address of the agent, broke	r, or other person to whom commis	sions or fees were paid			
(b) Amount of sales ar	nd base	Fe	ees and other commissions paid				
commissions pa	id	(c) Amount	(d) Purpos	(e) Organization code			
	(a) Name	and address of the agent, broke	r, or other person to whom commis	sions or fees were paid			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(b) Amount of sales ar	nd hase	Fe	ees and other commissions paid				
commissions pa		(c) Amount	(d) Purpos	se	(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 e		ourposes of
4 (	Curre	ent value of plan's interest under this contract in the general account at year	end		
<b>5</b> (	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		60	
		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 her	e <b>▶</b> ∏	
7 (	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma			
			ite participation guara		
	_				
		(3) guaranteed investment (4) other			
	_				
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
	d ·	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )		7d	
	e i	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	7e(4)		
		• · · · · · · · · · · · · · · · · · · ·			
		(5) Total deductions		7e(5)	0
		Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			

4

Schedule A	(Form 5500)	2010
Scriedule A	(	2010

Pa	art III	weitare 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	urposes if such contracts	are experienc	e-rated as a unit. Whe	ere contract	
8	Bene	fit and contract type (check all applicable boxes)					
	аГ	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disabilit	<u> </u>	Supplemental unemp		h Prescription drug
	i [	Stop loss (large deductible)	j HMO contract	y g_ k□	PPO contract	лоуппсти	
	_	, , , ,	J [] Thivio contract	ν_	FFO Contract		I Indemnity contract
	m _	Other (specify)					
a	Evne	rience-rated contracts:					
,	•	remiums: (1) Amount received		9a(1)			-
		Increase (decrease) in amount due but unpaid		9a(2)			-
		3) Increase (decrease) in unearned premium res					
		4) Earned ((1) + (2) - (3))				9a(4)	
	_	Benefit charges (1) Claims paid		9b(1)		σα( .)	
		Increase (decrease) in claim reserves		(-)			
		3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	
		4) Claims charged				9b(4)	
		Remainder of premium: (1) Retention charges (o				0.0(1)	
		(A) Commissions	,	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
		Status of policyholder reserves at end of year: (1	_			9d(1)	
		(2) Claim reserves	•			9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in <b>c(2)</b> .)		9e	
10	<b>N</b> or	experience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	
		If the carrier, service, or other organization incurr retention of the contract or policy, other than repo			•	10b	
		ecify nature of costs	oned in Part I, item 2 abov	ve, report am	ourit	100	
	Opt	rature or costs v					
_							
P	art IV	Provision of Information					

X Yes

No

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

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

OMB No. 1210-0110

nursuant to EDICA agetion 102(a)(2)					Form is Open to Public Inspection		
For calendar plan year 20	10 or fiscal pla	n year beginning 02/01/2010	and	d ending 01/31/2011	•		
A Name of plan	-	RICA HEALTH CARE TRUST		nree-digit lan number (PN)	501		
C Plan sponsor's name a AFFILIATED ASSOCIATI	ONS OF AME	RICA	20-	pployer Identification Num 1050245			
on a separat			Coverage, Fees, and Cos a unit in Parts II and III can be r				
1 Coverage Information:	Coverage Information:						
(a) Name of insurance ca UNITED HEALTHCARE I		COMPANY					
/L\	(c) NAIC	(d) Contract or	(e) Approximate number of		or contract year		
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To		
36-2739571	79413	301705	3868	05/01/2010	04/30/2011		
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 amount of commissions paid (b) Total amount of fees paid					id		
		0			0		
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all persons	).			
<u> </u>			, or other person to whom comm				
(b) Amount of sales ar			es and other commissions paid				
commissions pa	id	(c) Amount	(d) Purpose		(e) Organization code		
	(a) Name a	and address of the agent, broker	r, or other person to whom comm	issions or fees were paid	I		
(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount	<b>(d)</b> Purp	ose	(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 e		ourposes of
4 (	Curre	ent value of plan's interest under this contract in the general account at year	end		
<b>5</b> (	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		60	
		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 her	e <b>▶</b> ∏	
7 (	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma			
			ite participation guara		
	_				
		(3) guaranteed investment (4) other			
	_				
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
	d ·	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )		7d	
	e i	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	7e(4)		
		• · · · · · · · · · · · · · · · · · · ·			
		(5) Total deductions		7e(5)	0
		Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			

Page	4
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Pa	art III	If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of urpose	s if such co	ntracts a	are experi	enc	e-rated as a unit. Who	ere contrac		
8	Bene	fit and contract type (check all applicable boxes)	1					· · ·			
•	аГ	Health (other than dental or vision)		Dental		c	٠П	Vision		<b>d</b> X Life insur	ance
		i '	블		P 1 200		님				
	e _^	Temporary disability (accident and sickness)	ţ ∐	Long-term		_	ᆸ	Supplemental unemp	oloyment	h Prescripti	on drug
	i L	Stop loss (large deductible)	Ĵ∐	HMO conti	ract	k		PPO contract		I Indemnity	contract
	m	Other (specify)									
9	Evne	rience-rated contracts:									
•	•	remiums: (1) Amount received			Γ	9a(1)			23557	1	
		2) Increase (decrease) in amount due but unpai				9a(2)				-	
		3) Increase (decrease) in unearned premium re				9a(3)				-	
		(4) Earned ((1) + (2) - (3))							9a(4)		235571
		Benefit charges (1) Claims paid				9b(1)	T		<b>54(1)</b>		
		2) Increase (decrease) in claim reserves				/->					
		(3) Incurred claims (add (1) and (2))			_				9b(3)		
		4) Claims charged							9b(4)		
		Remainder of premium: (1) Retention charges (							,		
		(A) Commissions			′ r	9c(1)(A	)				
		(B) Administrative service or other fees				9c(1)(B					
		(C) Other specific acquisition costs			1	9c(1)(C	_				
		(D) Other expenses			-	9c(1)(D					
		(E) Taxes			Ī	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 amou	ints were	paid in	cash, or	_ c	redited.)	9c(2)		
		Status of policyholder reserves at end of year: (				L	_		9d(1)		
		(2) Claim reserves	•						9d(2)		
		(3) Other reserves							9d(3)		
	е	Dividends or retroactive rate refunds due. (Do n							9e		
10		nexperience-rated contracts:									
		Total premiums or subscription charges paid to	carrier						10a		
	b	If the carrier, service, or other organization incur	red an	y specific co	osts in co	onnection	with	n the acquisition or	10b		
		ecify nature of costs		•		•					
Pa	art IV	Provision of Information									
		the insurance company fail to provide any inform	nation	necessary t	o comple	ete Sched	عادا	Δ? Π	Yes	X No	
	ار	arango company ian to provide any inion		t	- comple		aio.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## **Insurance Information**

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

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

OMB No. 1210-0110

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					m is Open to Public Inspection			
For calendar plan year 20	10 or fiscal pla	an year beginning 02/01/201	0	and er	nding 01	/31/2011	•	
A Name of plan AFFILIATED ASSOCIATI			e-digit number (PI	N) •	501			
C Plan sponsor's name a AFFILIATED ASSOCIATI				<b>D</b> Emplo 20-105		ation Number (	EIN)	
		ning Insurance Contrac . Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance ca VISION SERVICE PLAN	rrier							
(1) FINI	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year	
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To	
91-6056925	47317	12256001	45	22	07/01/20	10	06/30/2011	
2 Insurance fee and composite descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents,	, brokers, and c	ther persons in	
(a) Total a	amount of con	nmissions paid		<b>(b)</b> To	otal amount	of fees paid	0	
2.5							0	
Persons receiving com		fees. (Complete as many entrie						
		and address of the agent, broke	ees and other commissio		ions or rees	were paid		
(b) Amount of sales ar commissions pai		(c) Amount	ees and other commission	(d) Purpose			(e) Organization code	
commissions par		(c) / uniouni		<b>(a)</b> 1 dipos			(c) organization odd	
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid		
		<b>V</b> /				·		
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose	9		(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

Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with each carrier may	be treated a	s a unit for purposes of
<b>4</b> C	urrent value of plan's interest under this contract in the general account at year	end	4	
	urrent value of plan's interest under this contract in separate accounts at year e		5	
_	ontracts With Allocated Funds:		•	
а	State the basis of premium rates •			
b	•		6b	
С	Premiums due but unpaid at the end of the year		. 6c	
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	6d	
	Specify nature of costs			
е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred  (3) ☐ other (specify) ▶	d annuity		
1	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan check here		
<b>7</b> C	ontracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other			
b			. 7b	
С	, ,			
	(2) Dividends and credits	. 7c(2)		
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additions		7c(6)	(
•	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )		7d	
(	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	7e(2)		
	(3) Transferred to separate account	7e(3)		
	(4) Other (specify below)	. 7e(4)		
	<b>•</b>			
	(5) Total deductions		7e(5)	(
1	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )		7f	

Page	4

Pa	rt III	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts of	oup of employees of the purposes if such contracts	are experienc	e-rated as a unit. Wh	ere contrac	
8	Benefi	it and contract type (check all applicable boxes)					
	а ∏	Health (other than dental or vision)	<b>b</b> Dental	cX	Vision		<b>d</b> Life insurance
	е ⊟	Temporary disability (accident and sickness)	f Long-term disabili	=	Supplemental unem	plovment	h Prescription drug
	:	Stop loss (large deductible)	j HMO contract	,	PPO contract	p.0,	I Indemnity contract
	- ∃		I I TIMO CONTIACT	<b>~</b> □	FFO Contract		I ☐ indemnity contract
	m 📙	Other (specify)					
<u>a</u>	Evnori	ence-rated contracts:					
3		emiums: (1) Amount received		9a(1)		114412	<u> </u>
		2) Increase (decrease) in amount due but unpaid		· · · ·			
		<ul><li>B) Increase (decrease) in amount due but unpaid</li><li>B) Increase (decrease) in unearned premium res</li></ul>					_
		l) Earned ((1) + (2) - (3))				9a(4)	114412
	_	Benefit charges (1) Claims paid				97872	
		2) Increase (decrease) in claim reserves				94	
		B) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)	97966
	•	l) Claims charged				9b(4)	
	,	Remainder of premium: (1) Retention charges (o				(-)	
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)		19450	
		(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)	19450
	(2	2) Dividends or retroactive rate refunds. (These	amounts were paid ir	cash, or	redited.)	9c(2)	
		Status of policyholder reserves at end of year: (1				9d(1)	
		2) Claim reserves	•			9d(2)	24468
	,	3) Other reserves				9d(3)	
	,	Dividends or retroactive rate refunds due. (Do no				. 9e	
10		experience-rated contracts:				1	
		otal premiums or subscription charges paid to c	arrier			. 10a	
		the carrier, service, or other organization incurr				10b	
		etention of the contract or policy, other than repo cify nature of costs	orted in Part I, Item 2 abo	ve, report amo	ount	. IUD	
D-	w4 IV/	Drovision of Information					
	rt IV	Provision of Information				Vac	No.
11	Did t	he insurance company fail to provide any inform	ation necessary to comp	ete Schedule	A?	Yes	No 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

► 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	10 or fiscal pla	an year beginning 02/01/2010	0	and er	nding 01	/31/2011	•	
A Name of plan AFFILIATED ASSOCIATION			e-digit number (Pl	N) •	501			
C Plan sponsor's name a AFFILIATED ASSOCIATION				<b>D</b> Emplo 20-105		ation Number (	EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca WASHINGTON DENTAL								
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year	
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To	
91-0621480	47341	504-508			02/01/20	10	01/31/2011	
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents	, brokers, and o	other persons in	
(a) Total amount of commissions paid (b) Total 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 who	m commissi	ions or fees	were paid		
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees	were paid		
(b) Amount of sales and base Fees and other commissions paid								
commissions pa		(c) Amount		(d) Purpose	9		(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

Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with each carrier may	be treated a	s a unit for purposes of
<b>4</b> C	urrent value of plan's interest under this contract in the general account at year	end	4	
	urrent value of plan's interest under this contract in separate accounts at year e		5	
_	ontracts With Allocated Funds:		•	
а	State the basis of premium rates •			
b	•		6b	
С	Premiums due but unpaid at the end of the year		. 6c	
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	6d	
	Specify nature of costs			
е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred  (3) ☐ other (specify) ▶	d annuity		
1	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan check here		
<b>7</b> C	ontracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other			
b			. 7b	
С	, ,			
	(2) Dividends and credits	. 7c(2)		
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additions		7c(6)	(
•	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )		7d	
(	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	7e(2)		
	(3) Transferred to separate account	7e(3)		
	(4) Other (specify below)	. 7e(4)		
	<b>•</b>			
	(5) Total deductions		7e(5)	(
1	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )		7f	

Pá	art II	Welfare Benefit Contract Informati	on					
		If more than one contract covers the same gro information may be combined for reporting pu the entire group of such individual contracts w	rposes if such	contracts are expe	rienc	ce-rated as a unit. Wh	ere contrac	
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> X Dental		С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-ter	rm disability	g	Supplemental unem	oloyment	h Prescription drug
	i [	Stop loss (large deductible)	j ∏HMO co	-	k	PPO contract	,	I Indemnity contract
	. L			miaci		110 contract		
	m	Other (specify)						
a	Evn	erience-rated contracts:						
9		Premiums: (1) Amount received		9a(1	١			_
	u	(2) Increase (decrease) in amount due but unpaid						_
		(3) Increase (decrease) in unearned premium rese						
		(4) Earned ((1) + (2) - (3))					9a(4)	
	b	Benefit charges (1) Claims paid			- 1		1 7	
		(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	an accrual ba	nsis)				
		(A) Commissions		9c(1)(	(A)			
		(B) Administrative service or other fees						
		(C) Other specific acquisition costs		- (1)				
		(D) Other expenses						
		(E) Taxes		2 (1)				_
		(F) Charges for risks or other contingencies		0 (4)				
		(G) Other retention charges					00(1)(U)	
		(H) Total retention					9c(1)(H)	
	٦	(2) Dividends or retroactive rate refunds. (These						
	d	Status of policyholder reserves at end of year: (1) (2) Claim reserves		•			9d(1) 9d(2)	
		(3) Other reserves					9d(2)	
	е	Dividends or retroactive rate refunds due. (Do no					9e	
10		nexperience-rated contracts:		cc.a c( <u>-</u> ).	,		1 00	
	а	Total premiums or subscription charges paid to ca	ırrier				10a	
	b	If the carrier, service, or other organization incurre	ed any specific	costs in connection	n wit	h the acquisition or		
		retention of the contract or policy, other than repo	rted in Part I, it	tem 2 above, repo	rt am	ount	10b	
	Sp	pecify nature of costs						
P	art l'	V Provision of Information						
7	ai til	V TOVISION OF INIONIATION						

X Yes

No

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

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 02/01/2010	and ending 01/31/2011	
A Name of plan AFFILIATED ASSOCIATIONS OF AMERICA HEALTH CARE TRUST	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Nu	ımber (EIN)
AFFILIATED ASSOCIATIONS OF AMERICA	20-1050245	,
Part I Service Provider Information (see instructions)		
Tatti por roo i roman momanon (sso monastrono)		
You must complete this Part, in accordance with the instructions, to report the inforr or more in total compensation (i.e., money or anything else of monetary value) in coplan during the plan year. If a person received <b>only</b> eligible indirect compensation that answer line 1 but are not required to include that person when completing the remains.	onnection with services rendered to the p for which the plan received the required of	lan or the person's position with the
1 Information on Persons Receiving Only Eligible Indirect Comp	pensation	
a Check "Yes" or "No" to indicate whether you are excluding a person from the remain	nder of this Part because they received o	only eligible
indirect compensation for which the plan received the required disclosures (see inst	ructions for definitions and conditions)	Yes 🛚 No
<b>b</b> If you answered line 1a "Yes," enter the name and EIN or address of each person preceived only eligible indirect compensation. Complete as many entries as needed		service providers who
(b) Enter name and EIN or address of person who provided	d you disclosures on eligible indirect com	pensation
(b) Enter name and EIN or address of person who provided	d you disclosure on eligible indirect comp	pensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect com	pensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect com	pensation

	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

Page 3	
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answered	d "yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN or	address (see instructions)		
AFFILIATE	ED SERVICES LLC		8767 148	TH AVE NE ID, WA 98052		
20-553961	1					
(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		1910407	Yes No X	Yes No X	0	Yes No No
			(a) Enter name and EIN or	address (see instructions)		
AFFILIATE	ED SERVICES LLC			BTH AVE NE ND, WA 98052		
20-553961	T	(4)	(0)	(6)	(a)	(h)
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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		748677	Yes No No	Yes No 🖺	0	Yes No No
1			(a) Enter name and EIN or	address (see instructions)		<u> </u>
BILL YEAC	GER			48TH AVE W SUITE 350 DOD, WA 98037		
53-144524	14					
(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	
22		96773	Yes No 🖺	Yes No X	0	Yes No X

<del>-</del>						
		(	a) Enter name and EIN or	address (see instructions)		
WASHINGT	FON DENTISTS INSU	RANCE AGENC	1001 - 4T SEATTLE	TH AVE 3800 E, WA 98154		
91-1499261	1					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	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		76478	Yes No X	Yes No 🖺	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
GALLAGHE	ER BENEFITS SERVI	CES INC		TH AVE NE JE, WA 98004		
36-4291971	1					
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	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		35911	Yes No 🖺	Yes No 🖺	0	Yes No 🖺
1		(	a) Enter name and EIN or	address (see instructions)		
MCM	MCM  1325 - 4TH AVE SUITE 2100 SEATTLE, WA 98101					
91-0851882	1					
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	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		35209	Yes No 🖺	Yes No 🖺	0	Yes No X

Page **4-**

	Schedule C (Form 550	00) 2010		Page <b>4-</b> ₽		
		(	a) Enter name and EIN or	address (see instructions)		
OLYMPIC (	CREST INSURANCE I	INC	PO BOX GIG HAR	2538 BOR, WA 98335		
91-1717576	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?	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		27013	Yes No X	Yes No 🖺	0	Yes No 🖺
		(	a) Enter name and EIN or	address (see instructions)	<u> </u>	
SMITHSON 53-758937	N INSURANCE SERVI	CES		EY MALL PARKWAY ENATCHEE, WA 98802		
(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?
22		22832	Yes No 🛚	Yes No 🛚	0	Yes No No
	(a) Enter name and EIN or address (see instructions)					
RHD EMPLOYEE BENEFITS  PO BOX 141389 SPOKANE VALLEY, WA 99214  91-1956494						
(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?

0

Yes No No

22

22

21431

Yes No X

Yes No X

Page <b>4-</b> <sup>3</sup>	

			a) Enter name and EIN or	address (see instructions)		
MADDOCK	AND ASSOCIATES		· •	AVE MADDOCK 1407 WILLOW	ROAD	
91-1280409	9					
(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		18424	Yes No X	Yes No 🖺	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
GREEN FIN	NANCIAL		PO BOX KIRKLAN	8036 ND, WA 98034		
91-1355214	4					
(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?
22		17051	Yes No 🖺	Yes No 🖺	0	Yes No No
		(	a) Enter name and EIN or	address (see instructions)		
ADVISOR E	BENEFITS			CLEARWATER SUITE 100 VICK, WA 99336		
91-1628862	2					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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		16962	Yes No 🖺	Yes No 🖺	0	Yes No X

	Schedule C (Form 550	00) 2010		Page <b>4-</b>		
-						
		(	a) Enter name and EIN or	address (see instructions)		
HUB INTE	RNATIONAL NW LLC		PO BOX BOTHEL	3018 L, WA 98041		
91-203601	5					
(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?
22		15071	Yes ☐ No 🏋	Yes No 🖺	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
HEALTHY	FAMILY INSURANCE	LLC	16706 E ELK, WA	OREGON RD		
53-750451	6		LLK, WA	33003		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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		14901	Yes No 🖺	Yes No 🛚	0	Yes No 🖺
(a) Enter name and EIN or address (see instructions)						
WEST COAST INSURANCE  PO BOX 189 VANCOUVER, WA 98666						
91-142849	5					
(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?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element	(h) Did the service provider give you a formula instead of an amount or estimated amount?

Yes No X

22

14604

Yes No X

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

0

Yes No X

F	age <b>4-</b> 5	

			a) =			
KIBBLE & F	PRENTICE	(		DN ST., 1000 E, WA 98101		
91-1176315	5					
(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?
22		14327	Yes No 🖺	Yes No 🖺	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
LINDHE IN	SURANCE			T MAIN STREET IDALE, WA 98620		
91-1537954	4					
(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?
22		13488	Yes No 🖺	Yes No 🛚	0	Yes No No
		(	a) Enter name and EIN or	address (see instructions)		
WALLINGF	ORD FINANCIAL SEF	RVICES	236 SE 1 NORMAN	71ST ST NDY PARK, WA 98166		
71-0907082	2					
(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?
22		12856	Yes No 🖺	Yes No 🖺	0	Yes No No

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			a) =			
ALEX SKO	ULIS	(	a) Enter name and EIN or PO BOX SEATTLE	,		
30-1725354	4					
(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		12811	Yes No X	Yes No 🖺	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
PREFERRE	ED BENEFIT SERVIC	ES	PO BOX POULSB	1310 O, WA 98370		
91-1703038	3					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	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		12127	Yes No 🖺	Yes No 🛚	0	Yes No No
1		(	a) Enter name and EIN or	address (see instructions)		
WILLIAM S	TANLEY CLU			25TH ST JE, WA 98004		
30-2382736	3					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(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?
22		10609	Yes No 🖺	Yes No 🖺	0	Yes No No
<u> </u>						

		(	a) Enter name and EIN or	address (see instructions)		
AUTOMOT	IVE BENEFITS CORF	PORATION	PO BOX MILL CRI	13170 EEK, WA 98082		
91-1409846	6					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	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		9803	Yes No 🖺	Yes No 🛚	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
HEFFERNA	AN INSURANCE BRO	KERS	PO BOX PORTLA	39038 ND, OR 97239		
94-2506099	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?
22		9796	Yes No 🖺	Yes No 🛚	0	Yes No 🛚
1		(	a) Enter name and EIN or	address (see instructions)		
COMPASS	CONSULTING			ST AVE S STE 322 E, WA 98134		
91-2089346	_	/ D	(-)	(0)	()	(1.)
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	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		9464	Yes No 🖺	Yes No 🖺	0	Yes No X

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Page <b>4-</b> 8	ı
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			->-			
RON COPF	DI F	(3	a) Enter name and EIN or	address (see instructions)		
KON COLL	LL			I, WA 98001-3845		
48-6486959	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?
22		9019	Yes No 🖺	Yes No 🖺	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
LAPORTE	& ASSOCIATES			MILWAUKIE AVE ND, OR 97202		
	_		TONIE	115, 511 57 202		
93-0775110	1					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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		8859	Yes No 🖺	Yes No 🛚	0	Yes No 🛚
		(	a) Enter name and EIN or	address (see instructions)		
MCALISTE	R & ASSOCIATES			IFE STREET A, WA 98406		
91-1937883	3					
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	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		8685	Yes No 🖺	Yes No 🖺	0	Yes No X

Page <b>4-</b>	

			<b>a)</b> Enter name and EIN or	addroce (con instructions)		
MICHAEL V	WARREN AGENCY	(	228 E MA	AIN STREET WALLA, WA 99362		
91-1425048	3					
(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?
22		8592	Yes No No	Yes No 🖺	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
DONNA CA	ARLSON			FREMONT ST WA 98607		
54-0489911	1					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	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		8379	Yes No 🖺	Yes No 🛚	0	Yes No No
1		(	a) Enter name and EIN or	address (see instructions)		
ETHIX NOF	RTHWEST		3309 56T GIG HAR	TH ST NW, 107 BOR, WA 98335		
13-4283589	)					
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	by the plan. If none,	(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		6073	Yes No No	Yes No 🖺	0	Yes No No

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- 3 -	

		(	a) Enter name and EIN or	address (see instructions)		
WASHINGT	TON RETAIL ASSOCI	ATION	PO BOX OLYMPIA	2227 A, WA 98507		
91-1376551						
(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?
22		5957	Yes No 🖺	Yes No 🖺	0	Yes No X
		(1	a) Enter name and EIN or	address (see instructions)		
CHERYL LAMPE  PO BOX S MOSES LAKE, WA 98837  53-2562012						
(b)	(0)	(4)	(a)	(6)	(m)	/b)
(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?
22		5295	Yes No 🖺	Yes 📗 No 🛚	0	Yes No 🖺
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Part I Service Provider Information (continued)		
3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect 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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Part II Service Providers Who Fail or Refuse to Provide Information							
4 Provide, to the extent possible, the following information for ea this Schedule.	ch service provide	r who failed or refused to provide the information necessary to complete					
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide					
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide					
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide					
(a) Enter name and EIN or address of service provider (see instructions)	<b>(b)</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)				
а	Name:	·	b EIN:	
С	Positio	n:		
d	Addres	s:	e Telephone:	
Ex	planatior			
a	Name:		<b>b</b> EIN:	
C	Positio	n:	D LIIV.	
d	Addres		e Telephone:	
_	7100100	•	• recognition.	
Fx	planatior	1		
	piariatio	•		
а	Name:		<b>b</b> EIN:	
С	Positio	n:		
d	Addres		e Telephone:	
Fv	planatior			
	piariatioi	•		
а	Name:		<b>b</b> EIN;	
C	Positio	n:	D LIIV,	
d	Addres		<b>e</b> Telephone:	
u	Addies	<b>3</b> .	С тетернопе.	
Ex	planatior	:	•	
а	Name:		b ein;	
С	Positio	n:		
d	Addres		e Telephone:	
Explanation:				

## 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

This Form is Open to Public Inspection

Part I Annual Report Identification In						
For calendar plan year 2010 or fiscal plan year begin	ning 02/01/		ding 01/31/2011			
A This return/report is for: a multiemployer pl	an;	X ar	nultiple-employer plan; or			
a single-employer	plan;	_ a [	DFE (specify)			
B This return/report is: the first return/rep	ort;	the	e final retum/report;			
an amended return	n/report;	☐ a s	short plan year return/report (less than 12 months			
C If the plan is a collectively-bargained plan, check here	e		▶			
D Check box if filing under: X Form 5558;		∐ au	tomatic extension;  the DFVC program;			
special extension						
Part II Basic Plan Information - enter all r	equested information					
1a Name of plan AFFILIATED ASSOCIATIONS OF A	MERICA HEAL	гн	1b Three-digit plan number (PN) ► 501			
CARE TRUST			1c Effective date of plan 0 2 / 0 1 / 2 0 0 7			
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)			2b Employer Identification Number (EIN) 20-1050245			
AFFILIATED ASSOCIATIONS OF A	MERICA		2c Sponsor's telephone number			
P.O. BOX 775			2d Business code (see instructions) 5 2 5 1 0 0			
REDMOND WA 9763 148TH AVE NE	98073					
REDMOND WA	98052					
Caution: A penalty for the late or incomplete filing of t	COLUMN CONTRACTOR	be assessed unless r	easonable cause is established.			
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete						
SIGN ALL A COLLY	11/04/2011	PATRICK A (				
Signature of plan administrator	Date	Enter name of individ	ual signing as plan administrator			
SIGN A CLIFF	11/4/2011	PATRICK A. CHESTNUT				
Signature of employer/plan sponsor	Date	Enter name of individ	ual signing as employer or plan sponsor			
SIGN HERE						
Signature of DFE	Date	Enter name of individ				
		-tour times for Forms !	F00 F000 (2010)			

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

Form 5500 (2010) V.092307.1