Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2010

	, , , , , , , , , , , , , , , , , , , ,				Inis Form is Open to Pt	ublic
Part I	Annual Report Iden	tification Information				
For cale	ndar plan year 2010 or fiscal p	plan year beginning 12/01/2010		and ending 11/30/	2011	
A This	return/report is for:	a multiemployer plan;	a multip	le-employer plan; or		
		X a single-employer plan;	a DFE (specify)		
B This	return/report is:	the first return/report;	the final	return/report;		
		an amended return/report;	a short p	olan year return/report (less t	han 12 months).	
C If the	plan is a collectively-bargaine	ed plan, check here	-			
	k box if filing under:	☐ Form 5558;	_	ic extension;	the DFVC program;	
D Onco	K box ii iiiiiig dildei.	special extension (enter des		,		
Part	II Rasic Plan Inform	nation—enter all requested information				
	ne of plan	iation—enter an requested informa	alion		1b Three-digit plan	504
	NC. HEALTH CARE BENEFIT	S PLAN			number (PN) ▶	504
,					1c Effective date of pl	an
					12/01/1996	
	sponsor's name and address ress should include room or s	s (employer, if for a single-employer	plan)		2b Employer Identification	
AHBL, II		uile no.)			Number (EIN) 91-0915991	
AHBL, II					2c Sponsor's telephor	ne
, ,					number	
2215 NC	ORTH 30TH STREET, SUITE	300 2215 NOF	RTH 30TH STREET	. SUITE 300	253-383-2422	
	A, WA 98403		, WA 98403	,	2d Business code (see instructions)	е
					541310	
0	A		-4 20 b d			
	•	complete filing of this return/repo				dulaa
		enalties set forth in the instructions, as the electronic version of this return				
						·
SIGN	Filed with authorized/valid ele	ectronic signature.	04/05/2012	TIMOTHY HANSEN		
HERE Signature of plan administrator Date Enter name of individual signing as plan administrator						
	Signature of plan adminis	trator	Date	Enter name of individual s	signing as pian administrator	
SIGN						
HERE	01		Data	Fatanasa (1 P.11 1	-turtum	
	Signature of employer/pla	n sponsor	Date	Enter name of individual s	signing as employer or plan sp	onsor
SIGN						
HERE						

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

Form 5500 (2010) v.092307.1

Enter name of individual signing as DFE

Form 5500 (2010) Page **2**

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") AHBL, INC.			3b Administrator's EIN 91-0915991		
	5 NORTH 30TH STREET, SUITE 300 COMA, WA 98403		nu	ministrator's telephone imber 3-383-2422	
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	/report filed for this plan, 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	89	
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	79	
b	Retired or separated participants receiving benefits		. 6b	2	
С	Other retired or separated participants entitled to future benefits		. 6c	0	
d	Subtotal. Add lines 6a , 6b , and 6c		. 6d	81	
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits	. 6e		
			. 6f	81	
'	Total. Add lines 6d and 6e		. 01	01	
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		
	If the plan provides pension benefits, enter the applicable pension feature co f the plan provides welfare benefits, enter the applicable welfare feature codes 4A 4D 4E 4R	s from the List of Plan Characteristic Codes in	n the inst	tructions:	
9a	Plan funding arrangement (check all that apply) (1) Insurance	9b Plan benefit arrangement (check all that (1) Insurance	at apply)		
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)	insuranc	ce contracts	
	(3) Trust	(3) Trust			
10	(4) General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are a	(4) Seneral assets of the spatial trached, and, where indicated, enter the number		ched. (See instructions)	
а	Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money	b General Schedules (1) H (Financial Inform (2) I (Financial Inform	nation)		
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3) X 2 A (Insurance Infor C (Service Provide	er Inform	,	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) D (DFE/Participati (6) G (Financial Trans	-		

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 Co	rporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				This Form is Open to Public Inspection	
For calendar plan year 20°	10 or fiscal pla	an year beginning 12/01/201	0	and en	ding 11	/30/2011	
A Name of plan AHBL, INC. HEALTH CAR	·			B Three plan r	-digit number (PI	v) •	504
C Plan sponsor's name a AHBL, INC.	s shown on li	ne 2a of Form 5500.		D Employ 91-0918		ation Number (EIN)
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrier	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	policy or contract		(f)	From	(g) To
25-0687550	19445	280-8771	8	31	12/01/20	10	11/30/2011
	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 a	amount of cor	nmissions paid		(b) Tot	al amount	of fees paid	
3 Persons receiving com	missions and	989 fees. (Complete as many entrice		nersons)			0
• 1 crooms receiving com		and address of the agent, broke			ons or fees	were naid	
FLEXIBLE BENEFITS CO		N PO	BOX 1894 COMA, WA 98401				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code
						3	
	(a) Name	and address of the agent, broke	er, or other person to who	n commissio	ons or fees	were paid	
(b) Amount of sales and base Fees and other commissions paid							
commissions pai	d	(c) Amount		(d) Purpose			(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) additional invocations (e) are a			
	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	

Pac	ie	4

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the

Part III

Welfare Benefit Contract Information

8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) b Dental C Vision d Life insurance e Temporary disability (accident and sickness) f Long-term disability g Supplemental unemployment h Prescription drug l I Indemnity contract m Protection drug m Prote			information may be combined for reporting p the entire group of such individual contracts					ts cover individual employees,
Beath (other than dental or vision b Dental c Vision d Ufe insurance Temporary disability (accident and sickness) f Long-term disability g Supplemental unemployment h Prescription drug m Dental s Dental s Dental g Supplemental unemployment h Prescription drug m Dental s Den	8	Bene	fit and contract type (check all applicable boxes)	· · · · · · · · · · · · · · · · · · ·		·	· ·	
i Stop loss (large deducible) j HMO contract k PPO contract l Indemnity contract l I		_			С	Vision		d Life insurance
i Stop loss (large deducible) j HMO contract k PPO contract l Indemnity contract l I		еĒ	Temporary disability (accident and sickness)	f Long-term disabili	tv q	Supplemental unen	nployment	h Prescription drug
Pert IV Provision of Information Pert IV Provision of Information Part IV Provision of Information Part IV Provision of Information Page(1)		i F				1	1 -7	
9 Experience-rated contracts: a Premiums: (1) Amount received. (2) Increase (decrease) in amount due but unpaid. (3) Increase (decrease) in uncerned premium reserve. 9a(3) (4) Eamed ((1) + (2) - (3)). 9a(4) (5) Benefit charges (1) Claims paid. (6) Increase (decrease) in claim reserves. 9b(2) (7) Increase (decrease) in claim reserves. 9b(2) (8) Incurred claims (add (1) and (2)). (9) Commissions. (9) Commissions. (9) Commissions. (9) Commissions. (9) Administrative service or other fees. (10) Other expenses. (m X				11 0 contidor		
a Premiums: (1) Amount received			Other (specify)					
a Premiums: (1) Amount received	9	Expe	rience-rated contracts:					
(2) Increase (decrease) in amount due but unpaid. (3) Increase (decrease) in unearned premium reserve. (4) Earned ((f) + (2) - (3)) (5) Benefit charges (1) Claims paid. (7) Increase (decrease) in claim reserves. (8) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (A) Claims charged. (B) Administrative service or other fees. (B) Administrative service or other fees. (C) Other specific acquisition costs. (D) Other specific acquisition costs. (E) Taxes. (C) Other specific acquisition costs. (D) Other specific acquisition costs. (E) Taxes. (C) Other specific acquisition costs. (D) Other specific acquisition costs. (E) Taxes. (D) Other specific acquisition costs. (E) Taxes. (D) Other specific acquisition or expecific costs or other costs. (E) Taxes. (D) Other reserves. (D) Other reserve	•				9a(1)			
(3) Increase (decrease) in uneamed premium reserve. (4) Earned ((1) + (2) - (3)). (5) Benefit charges (1) Claims paid. (2) Increase (decrease) in claim reserves. (3) Increase (decrease) in claim reserves. (3) Increase (decrease) in claim reserves. (4) Claims charged. (5) CRemainder of premium: (1) Retention charges (on an accrual basis) (6) Commissions (7) Commissions (8) Administrative service or other fees. (9) C(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)								
b Benefit charges (1) Claims paid. (2) Increase (decrease) in claim reserves. (3) Incured claims (add (1) and (2)). (4) Claims charged. (A) Commissions. (B) Administrative service or other fees. (C) Other specific acquisition costs. (D) Other expenses. (E) Taxes. (F) Charges for risks or other contingencies. (F) Charges for risks or other contingencies. (C) Other decrease and other contingencies. (D) Utiden costs. (E) Taxes. (F) Charges for risks or other contingencies. (C) Dividends or retroactive rate refunds. (These amounts were □ paid in cash, or □ credited.) (C) Claim reserves. (D) Other reserves at end of year: (1) Amount held to provide benefits after retirement. (C) Claims charges. (D) Other expenses. (D) Other expenses. (E) Taxes. (D) Other expenses. (E) Taxes. (D) Other expenses. (E) Taxes. (F) Charges for risks or other contingencies. (E) Total retention. (2) Dividends or retroactive rate refunds. (These amounts were □ paid in cash, or □ credited.) (C) Claim reserves. (D) Other expenses. (D) Other expenses. (E) Total retention. (D) Other expenses. (D) Other expenses. (E) Total retention. (D) Other expenses. (D) Other e								
(2) Increase (decrease) in claim reserves. (3) Incurred claims (add (1) and (2)). (4) Claims charged. (B) Administrative service or other fees. (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 to carrier. (2) Dividends or retroactive rate refunds due. (Do not include amount entered in c(2)). (E) Taxes. (B) Administrative service or other one of the fees. (C) Other specific acquisition costs. (C) Other reserves at end of year: (1) Amount held to provide benefits after retirement. (C) Dividends or retroactive rate refunds due. (Do not include amount entered in c(2)). (E) Taxes. (D) Total retention of the contracts: (E) Dividends or retroactive rate refunds due. (Do not include amount entered in c(2)). (E) Taxes. (D) Total retention of the contracts: (E) Dividends or retroactive rate refunds due. (Do not include amount entered in c(2)). (E) Taxes. (E) Taxes. (D) Total retention or retroactive rate refunds due. (Do not include amount entered in c(2)). (E) Total retention of the contract or policy, other than reported in Part I, item 2 above, report amount. (D) Dividends or retroactive rate refunds due. (D) Nonexperience-rated contracts: (D) Total retention or the contract or policy, other than reported in Part I, item 2 above, report amount. (D) Dividends or retroactive rate refunds or retroactive rate refunds due. (D) Dividends or r		(4) Earned ((1) + (2) - (3))				9a(4)	
(3) Incurred claims (add (1) and (2)). (4) Claims charged. C Remainder of premium: (1) Retention charges (on an accrual basis) — (A) Commissions. (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 clother contingencies. (2) Claim reserves. (3) Other reserves at end of year: (1) Amount held to provide benefits after retirement. (3) Other reserves. (3) Other reserves. (3) Other reserves. (4) Dividends or retroactive rate refunds due. (Do not include amount entered in c(2)). (b) Total premiums or subscription charges paid to carrier. (a) Total premiums or subscription charges paid to carrier. (b) 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. (b) Provision of Information		b	Benefit charges (1) Claims paid		9b(1)			
(4) Claims charged. C Remainder of premium: (1) Retention charges (on an accrual basis) — (A) Commissions ————————————————————————————————————		(2) Increase (decrease) in claim reserves		9b(2)			
C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions (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.) (2) Claim reserves (3) Other reserves at end of year: (1) Amount held to provide benefits after retirement (3) Other reserves (4) Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier a Total premiums or subscription charges paid to carrier b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount Part IV Provision of Information		(3) Incurred claims (add (1) and (2))					
(A) Commissions. (B) Administrative service or other fees. (C) Other specific acquisition costs. (D) Other expenses. (E) Taxes		,	, ,				9b(4)	
(B) Administrative service or other fees		С						
(C) Other specific acquisition costs			• •					
(D) Other expenses			· /					
(E) Taxes			• • • • • • • • • • • • • • • • • • • •					
(F) Charges for risks or other contingencies 9c(1)(F) 9c(1)(G) 9c(2) 9c(1)(G) 9c(2) 9c(1)(G) 9c(2) 9c(1)(G) 9c(2)			·		· · · · ·			
(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: a Total premiums or subscription charges paid to carrier. 10a 9887 b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount. 10b Specify nature of costs Part IV Provision of Information							9c(1)(H)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement				_				
(2) Claim reserves					<u></u>			
(3) Other reserves								
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retention of the contract or policy, other than reported in Part I, item 2 above, report amount		а	Total premiums or subscription charges paid to	carrier			10a	9887
Specify nature of costs Part IV Provision of Information							401	
Part IV Provision of Information				orted in Part I, item 2 abo	ve, report am	ount	10b	
		Spe	ecity nature of costs 🕨					
	Pa	art IV	Provision of Information					
				nation necessary to comp	lete Schedule	A?	Yes	X No

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 dualanty of	эгроганоп	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection				
For calendar plan year 20	10 or fiscal plar	n year beginning 12/01/2010	and e	nding 11/30/2011					
A Name of plan AHBL, INC. HEALTH CA	RE BENEFITS	PLAN		e-digit number (PN)	504				
C Plan sponsor's name a AHBL, INC.	as shown on line	e 2a of Form 5500.	D Emplo	oyer Identification Numbe	r (EIN)				
on a separa	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									
(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				
35-1817054	92711	HCL10421	81	12/01/2010	11/30/2011				
	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 comr	missions paid	(b) To	otal amount of fees paid					
		19924			0				
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all persons).						
		nd address of the agent, broker, o		ions or fees were paid					
FLEXIBLE BENEFITS CO		PO BC	0X 1824 MA, WA 98401						
(b) Amount of sales a	nd base	Fees	and other commissions paid						
commissions pa		(c) Amount	(d) Purpos	(e) Organization code					
19924					3				
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	ions or fees were paid					
	(4)								
(h) Amount of sales as	nd hase	Fees	and other commissions paid						
(b) Amount of sales and base commissions paid (c) Amount		(c) Amount	(d) Purpos	(e) Organization code					
	A 4 N1 41	101100 4 111 1			/= =====				

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
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(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid	
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(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
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	• •			
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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			
	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
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Part III Welfare Benefit Contract Inform If more than one contract covers the same information may be combined for reporting the entire group of such individual contract	e group of employees of the group of employees of the	are experience	e-rated as a unit. Wh	ere contrac		
8 Benefit and contract type (check all applicable box	es)					
a Health (other than dental or vision)	b Dental	c 🗌	Vision		d Life insurance	
e Temporary disability (accident and sickness) f Long-term disabi	lity \mathbf{g}	Supplemental unem	ployment	h Prescription drug	
i Stop loss (large deductible)	j HMO contract	, k∏	PPO contract		I Indemnity contract	
m ☐ Other (specify) ▶	, 🗀	🗀			I macming contract	
III Utiler (specify)						
9 Experience-rated contracts:						
a Premiums: (1) Amount received		9a(1)				
(2) Increase (decrease) in amount due but un						
(3) Increase (decrease) in unearned premium						
(4) Earned ((1) + (2) - (3))				9a(4)		
b Benefit charges (1) Claims paid				,		
(2) Increase (decrease) in claim reserves						
(3) Incurred claims (add (1) and (2))				9b(3)		
(4) Claims charged				9b(4)		
c Remainder of premium: (1) Retention charges	s (on an accrual basis)					
(A) Commissions		9c(1)(A)				
(B) Administrative service or other fees						
(C) Other specific acquisition costs						
(D) Other expenses						
(E) Taxes		0 (4)(=)				
(F) Charges for risks or other contingencie					_	
(G) Other retention charges				0.(4)(1)		
(H) Total retention	_	_		9c(1)(H)	<u> </u>	
(2) Dividends or retroactive rate refunds. (Th						
d Status of policyholder reserves at end of year	• •			9d(1)		
(2) Claim reserves				9d(2)		
(3) Other reserves				9d(3)		
Dividends or retroactive rate refunds due. (D	o not include amount entere	ed in c(2) .)		9e		
10 Nonexperience-rated contracts:	io corrier			100	123382	
a Total premiums or subscription charges paid				10a	120002	
b If the carrier, service, or other organization incretention of the contract or policy, other than in				10b		
Specify nature of costs	oponiou iii i ait i, noiii 2 ab	ovo, roport ame				
openity flattere of doubte 7						
Part IV Provision of Information						
				Vac	No No	
11 Did the insurance company fail to provide any inference	ormation necessary to com	piete Schedule	A?	Yes	^X No	

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

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.

Pension Benefit Guaranty Corporation	inspection.				
For calendar plan year 2010 or fiscal plan year beginning 12/01/2010	and ending 11/30/2011				
A Name of plan	B Three-digit				
AHBL, INC. HEALTH CARE BENEFITS PLAN	plan number (PN)				
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)				
AHBL, INC.	91-0915991				
Part I Service Provider Information (see instructions)					
You must complete this Part, in accordance with the instructions, to report the informat or more in total compensation (i.e., money or anything else of monetary value) in conneplan 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 remainded	ection with services rendered to the plan or the person's position which the plan received the required disclosures, you are required	with the			
1 Information on Persons Receiving Only Eligible Indirect Comper	nsation				
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainde					
indirect compensation for which the plan received the required disclosures (see instruc	etions for definitions and conditions)	No			
		_			
b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).					
(b) Enter name and EIN or address of person who provided you	ou disclosures on eligible indirect compensation				
(b) Enter name and EIN or address of person who provided yo	ou disclosure on eligible indirect compensation				
(b) Enter name and EIN or address of person who provided yo	ou disclosures on eligible indirect compensation				
	· ·				
(b) Enter name and EIN or address of person who provided yo	ou disclosures on eligible indirect componention				
(b) Enter hame and Envior address of person who provided yo	a disclosures on eligible mallect compensation				

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	(b) Enter name and EIN or address of person when the contract of the contract	ho provided you disclosures on eligible ind	irect compensation
	(b) Enter name and EIN or address of person when the control of th	ho provided you disclosures on eligible ind	irect compensation
	(b) Enter name and EIN or address of person when the contract of the contract	ho provided you disclosures on eligible ind	irect compensation
	(b) Enter name and EIN or address of person when the contract of the contract	ho provided you disclosures on eligible ind	irect compensation
	(b) Enter name and EIN or address of person when the contract of the contract	ho provided you disclosures on eligible ind	irect compensation
	(b) Enter name and EIN or address of person when the contract of the contract	ho provided you disclosures on eligible ind	irect compensation
	(b) Enter name and EIN or address of person when the contract of the contract	ho provided you disclosures on eligible ind	irect compensation
1	(b) Enter name and EIN or address of person wi	ho provided you disclosures on eligible ind	irect compensation

answered	d "yes" to line 1a above	e, complete as many e	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or 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)		
TRUSTEE	D PLANS SERVICE C		PO BOX			
91-078058	88					
(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	NONE	24358	Yes No X	Yes No 🖺	0	Yes No No
		(a) Enter name and EIN or	address (see instructions)		
91-127276 (b)	OICE HEALTH NETW	(d)		VERSITY STREET, SUITE 140 E, WA 98101	(g)	(h)
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	Did the service provider give you a formula instead of an amount or
49	NONE	5451	Yes No No	Yes No 🖺	0	Yes No No
1		((a) Enter name and EIN or	address (see instructions)		
(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 (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

	Schedule C (Form 550	00) 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		

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Pa	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 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.			