### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Signature of DFE

## Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), 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

2011

This Form is Open to Public

					Inspection	
Part I	Annual Report Identi	fication Information				
For cale	ndar plan year 2011 or fiscal pla	n year beginning 02/01/2011		and ending 01/31	/2012	
<b>A</b> This	return/report is for:	a multiemployer plan;	× a multiple	e-employer plan; or		
		a single-employer plan;	a DFE (s	pecify)		
		_	_			
<b>B</b> This	return/report is:	the first return/report;	the final	return/report;		
	otam/roport io.	an amended return/report;	a short p	lan year return/report (less	than 12 months).	
C If the	plan is a collectively bargained	plan, check here			. П	
			_		D the DEVC are area	
D Chec	k box if filing under:	Form 5558;	ш	c extension;	the DFVC program;	
		special extension (enter des	cription)			
Part	II Basic Plan Informa	ntion—enter all requested informa	ation			1
	ne of plan				<b>1b</b> Three-digit plan	501
AFFILIA	TED ASSOCIATIONS OF AME	RICA HEALTH CARE TRUST			number (PN) ▶ <b>1c</b> Effective date of pla	
					02/01/2007	all
<b>2a</b> Plar	sponsor's name and address. i	including room or suite number (En	nplover, if for single-	emplover plan)	2b Employer Identifica	tion
	,, ·				Number (EIN)	
AFFILIA	TED ASSOCIATIONS OF AME	RICA			20-1050245	
					<b>2c</b> Sponsor's telephone	
					number	
P.O. BO			NORTHUP WAY, S	UITE 200	2d Business code (see	
KIRKLAI	ND, WA 98033	KIRKLANI	D, WA 98033		instructions)	-
					525100	
Coution	. A nanalty for the late or ince	amplete filing of this return/rener	t will be accessed	unlaca raacanahla asusa	is astablished	
		mplete filing of this return/repornal nalties set forth in the instructions, I				duloo
		the electronic version of this return				
SIGN	Filed with authorized/valid elect	ronic signature.	11/15/2012	PATRICK A CHESTNUT		
HERE	01		Date	Fatanasa a Cadada da at	-tautan and a salah ada tatamatan	
	Signature of plan administra	ator	Date	Enter name of individual	signing as plan administrator	
SIGN						
HERE						
	Signature of employer/plan	sponsor	Date	Enter name of individual	signing as employer or plan sp	onsor
OLON						
SIGN						

Date

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

Form 5500 (2011) v.012611

Enter name of individual signing as DFE

Form 5500 (2011) Page **2** 

	Plan administrator's name and address (if same as plan sponsor, enter "Sam FILIATED ASSOCIATIONS OF AMERICA	ne")			ministrator's EIN -1050245		
	D. BOX 3265 RKLAND, WA 98033				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	s plan, enter the name, EIN a	and	4b EIN		
а	Sponsor's name				4c PN		
5	Total number of participants at the beginning of the plan year			5	8444		
6	Number of participants as of the end of the plan year (welfare plans complete	e only lines 6a, 6b,	, <b>6c</b> , and <b>6d</b> ).				
а	Active participants			6a	6634		
					40		
b	Retired or separated participants receiving benefits			6b	16		
С	Other retired or separated participants entitled to future benefits			6c	137		
d	Subtotal. Add lines 6a, 6b, and 6c			6d	6787		
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	multiemployer pla	ns complete this item)	7			
	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:  b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:  4A 4B 4D 4E						
9a	Plan funding arrangement (check all that apply)		t arrangement (check all that	t apply)			
	(1) Insurance (2) Code section 412(e)(3) insurance contracts	(1) X (2)	Insurance Code section 412(e)(3) ir	neurano	e contracte		
	(3) Trust	(3)	Trust	isuranc	oc contracts		
	(4) General assets of the sponsor	(4)	General assets of the spo	onsor			
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, wher	re indicated, enter the number	er attac	hed. (See instructions)		
а	Pension Schedules	b General Sc	chedules				
	(1) R (Retirement Plan Information)	(1)	H (Financial Inform	ation)			
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Informa		Small Plan)		
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3) X	_4 A (Insurance Inform	,	ation)		
	·	(4) X (5)	C (Service Provider D (DFE/Participatin				
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(6)	G (Financial Transa	-			

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

pursuant to ERISA section 103(a)(2).				nspection				
For calendar plan year 20°	11 or fiscal pla	an year beginning 02/01/2011		and end	ding 01	1/31/2012	•	
A Name of plan AFFILIATED ASSOCIATION	ONS OF AME	RICA HEALTH CARE TRUST		B Three plan	-digit number (P	N) •	501	
C Plan sponsor's name a AFFILIATED ASSOCIATION				<b>D</b> Employ 20-1050		cation Number (I	EIN)	
on a separat	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								
	( ) ) ) ( )	4000	(e) Approximate nu	mber of		Policy or co	ntract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at policy or contract	end of	(f)	) From	<b>(g)</b> To	
36-2739571	91529	666	404	9	05/01/20	011	04/30/2012	
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 com	nmissions paid		<b>(b)</b> To	tal amount	of fees paid		
0								
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all p	ersons).				
	(a) Name	and address of the agent, broker	, or other person to whon	n commissi	ons or fees	s were paid		
(b) Amount of sales ar	nd base	Fe	es and other commission	s paid				
commissions pai		(c) Amount	(	d) Purpose			(e) Organization code	
	(a) Name	and address of the agent, broker	or other person to whon	n commissi	ons or fees	s were paid		
	(4)	and dad oct of the agon, pronor	, e- ee. pereen e					
(b) Amount of sales ar	nd base	Fe	es and other commission	s paid				
commissions pai		(c) Amount	(	d) Purpose	1		(e) Organization code	

Schedule A (Form 5500)	2011	Page <b>2 -</b> 1	]	
	ame and address of the agent, broke	r. or other person to whom o	commissions or fees were paid	
(4)	and address of the agont, siene	., c. carer percent to innern		
(L) A		Fees and other commission	s paid	(-) ()
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code
•	, ,			
<b>(a)</b> Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	s paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
<b>(a)</b> Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid	
	I			T
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	ame and address of the agent, broke	r or other person to whom o	commissions or fees were paid	
(a) (ve	and address of the agent, broke	r, or other person to whom t	commissions of fees were paid	
	I			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commission	s paid (d) Purpose	(e) Organization
commissions paid	(c) Amount		(d) Fulpose	code
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				
		, ,	•	
		Fees and other commission	naid	T.,
(b) Amount of sales and base commissions paid	(c) Amount	1 003 and other commission	(d) Purpose	(e) Organization code
Commissions paid	(o) / anount		(±). 3.5000	
				1

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts	with each carrier mag	y be treated	d as a unit for purposes of
4	Curre	nt value of plan's interest under this contract in the general account at year	end		. 4	
_		nt value of plan's interest under this contract in separate accounts at year e			. 5	
6	Contr	acts With Allocated Funds:				
	а	State the basis of premium rates				
		Premiums paid to carrier			6b	
		Premiums due but unpaid at the end of the year			. 6c	
		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	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan che	ck here		
7		acts With Unallocated Funds (Do not include portions of these contracts ma				
			ate participation	,		
	-			<b>3</b>		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
		Additions: (1) Contributions deposited during the year			1 10	
		(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)			
	ı					
					7-(0)	
	_	(6)Total additions			7c(6)	0
		otal of balance and additions (add <b>b</b> and <b>c(6)</b> ).			. 7d	
		Deductions:	70/4			
	,	(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)			
	١	•				
	(	5) Total deductions			. 7e(5)	0
	,	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			. 7f	

		Schedule A (Form 5500) 2011		Pa	age <b>4</b>		
Pa	art III	Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the surposes if such contracts	are experien	ce-rated as a unit. Wh	nere contract	ployee organizations(s), the ts cover individual employees,
8	Benefi	t and contract type (check all applicable boxes)	ŀ				
	а	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	ty <b>g</b>	Supplemental unem	ployment	h Prescription drug
	iП	Stop loss (large deductible)	j HMO contract	k [	PPO contract		I Indemnity contract
		Other (specify)	,	L			
	⊔	Carlot (specify)					
9	Experi	ence-rated contracts:					
	<b>a</b> Pr	emiums: (1) Amount received		9a(1)			
	(2	) Increase (decrease) in amount due but unpai	d	9a(2)			
	(3	s) Increase (decrease) in unearned premium re	serve	9a(3)			
	(4	Earned ( <b>(1) + (2) - (3)</b> )				. 9a(4)	
	<b>b</b> B	Senefit charges (1) Claims paid		9b(1)			
	(2	) Increase (decrease) in claim reserves		9b(2)			
	(3	s) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)	
	(4	) Claims charged				. 9b(4)	
	C R	temainder of premium: (1) Retention charges (	on an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies.		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				. 9c(1)(H)	
	(2	2) Dividends or retroactive rate refunds. (These	e amounts were paid in	cash, or	credited.)	9c(2)	
	d s	status of policyholder reserves at end of year: (	) Amount held to provide	benefits afte	r retirement	_ , ,	

9d(2)

9d(3)

9e

10a

10b

Specify nature of costs	Þ

10 Nonexperience-rated contracts:

Part IV	Provision of Information				
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A2	X	Yes	□ No	

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

retention of the contract or policy, other than reported in Part I, item 2 above, report amount......

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

pursuant to ERISA section 103(a)(2).					-		
For calendar plan year 20	11 or fiscal pla	an year beginning 02/01/2011	and	ending 01/31/2012			
A Name of plan AFFILIATED ASSOCIATION	ONS OF AME	ERICA HEALTH CARE TRUST		an number (PN)	501		
C Plan sponsor's name as shown on line 2a of Form 5500 AFFILIATED ASSOCIATIONS OF AMERICA  D Employer Identification Number (EIN) 20-1050245							
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		COMPANY					
ONTED TIE/RETTIO/IRE I	THOOTH HOL	OOM 700					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		contract year		
(0) =	code	identification number	policy or contract year	(f) From	<b>(g)</b> To		
36-2739571	79413	301705	4049	05/01/2011	04/30/2012		
2 Insurance fee and com descending order of the			otal commissions paid. List in iten	n 3 the agents, brokers, and	d other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid							
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 comm	issions or fees were paid			
(b) Amount of sales ar	nd hase	F	ees and other commissions paid				
commissions pa		(c) Amount	(d) Purp	ose	(e) Organization code		
	(a) Name	and address of the agent, broke	r, or other person to whom comm	issions or fees were paid			
	Т						
<b>(b)</b> Amount of sales ar commissions pa		(c) Amount	ees and other commissions paid (d) Purp	000	(e) Organization code		
commissions pa	iu	(C) Amount	( <b>a)</b> Purp	US <del>C</del>	(e) Organization code		

Schedule A (Form 5500)	2011	Page <b>2 -</b> 1	]	
	ame and address of the agent, broke	r. or other person to whom o	commissions or fees were paid	
(4)	and address of the agont, siene	., c. carer percent to innern		
(L) A		Fees and other commission	s paid	(-) ()
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code
•	, ,			
<b>(a)</b> Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	s paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
<b>(a)</b> Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid	
	I			T
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	ame and address of the agent, broke	r or other person to whom o	commissions or fees were paid	
(a) (ve	and address of the agent, broke	r, or other person to whom t	commissions of fees were paid	
	I			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commission	s paid (d) Purpose	(e) Organization
commissions paid	(c) Amount		(d) Fulpose	code
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				
		, ,	•	
		Fees and other commission	naid	T.,
(b) Amount of sales and base commissions paid	(c) Amount	1 003 and other commission	(d) Purpose	(e) Organization code
Commissions paid	(o) / anount		(±). 3.5000	
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Part II		Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a uthis report.							
4	Curre	nt value of plan's interest under this contract in the general account at year	end		. 4				
_		nt value of plan's interest under this contract in separate accounts at year e			. 5				
6	Contr	acts With Allocated Funds:							
	а	State the basis of premium rates							
		Premiums paid to carrier			6b				
		Premiums due but unpaid at the end of the year			. 6c				
		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	d annuity						
		(3) other (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan che	ck here					
7		acts With Unallocated Funds (Do not include portions of these contracts ma							
			ate participation	,					
	-			<b>3</b>					
		(3) guaranteed investment (4) other							
	b	Balance at the end of the previous year			7b				
		Additions: (1) Contributions deposited during the year			1 10				
		(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)						
	ı								
					7-(0)				
	_	(6)Total additions			7c(6)	0			
		otal of balance and additions (add <b>b</b> and <b>c(6)</b> ).			. 7d				
		Deductions:	70/4						
	,	(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)						
	١	•							
	(	5) Total deductions			. 7e(5)	0			
	,	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			. 7f				

		Schedule A (Form 5500) 2011		Pag	ge <b>4</b>		
_							
Pa	art II	I Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pr the entire group of such individual contracts of	roup of employees of the sa urposes if such contracts are	e experienc	e-rated as a unit. Whe	ere contract	
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		d X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	g∏	Supplemental unemp	loyment	h Prescription drug
	i [	Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract
	m	Other (specify)	• 🗆				<b>□</b> ,
	٠۲	_ Curer (specify) /					
9	Ехре	erience-rated contracts:					
	a	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium res	serve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (c	n an accrual basis)				
		(A) Commissions	9	9c(1)(A)			
		(B) Administrative service or other fees	9	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.	<u></u>	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 c	ash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1	) Amount held to provide be	enefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	

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

9e

10a

10b

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

a Total premiums or subscription charges paid to carrier.....

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.....

10 Nonexperience-rated contracts:

Specify nature of costs >

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 2011 or fiscal plan year beginning 02/01/2011 and ending 01/31/2012						/31/2012	•	
A Name of plan AFFILIATED ASSOCIATION	ONS OF AME	RICA HEALTH CARE TRUST			e-digit number (Pl	N) •	501	
C Plan sponsor's name a AFFILIATED ASSOCIATION				<b>D</b> Emplo	-	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 car	rrier							
			(e) Approximate n	umbor of		Policy or co	ontract year	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	at end of	(f)	From	(g) To	
91-6056925	47317	12256001	38	,	07/01/20	11	06/30/2012	
2 Insurance fee and common descending order of the		nation. Enter the total fees and t	total commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in	
		nmissions paid		<b>(b)</b> To	tal amount	of fees paid		
		0					0	
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).				
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid		
(h) Amount of color on	4 5	F	ees and other commissio	ns paid				
(b) Amount of sales an commissions pai		(c) Amount		(d) Purpose			(e) Organization code	
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid		
<b>(b)</b> Amount of sales an	nd hase	F	ees and other commissio	ns paid				
commissions pai		(c) Amount		(d) Purpose			(e) Organization code	

Schedule A (Form 5500)	2011	Page <b>2 -</b> 1	]		
	ame and address of the agent, broke	r. or other person to whom o	commissions or fees were paid		
(4)	and address of the agont, siene	., c. carer percent to innern			
(L) A		Fees and other commission	s paid	(-) ()	
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code	
•	, ,				
<b>(a)</b> Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid		
(b) Amount of sales and base		Fees and other commission	s paid	(e) Organization	
commissions paid	(c) Amount		(d) Purpose	code	
<b>(a)</b> Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid		
	I			T	
(b) Amount of sales and base		Fees and other commission		(e) Organization	
commissions paid	(c) Amount		(d) Purpose	code	
(a) Na	ame and address of the agent, broke	r or other person to whom o	commissions or fees were paid		
(a) (ve	and address of the agent, broke	r, or other person to whom t	commissions of fees were paid		
	I				
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commission	s paid (d) Purpose	(e) Organization	
commissions paid	(c) Amount		(d) Fulpose	code	
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid		
		, ,	•		
		Fees and other commission	naid	T.,	
(b) Amount of sales and base commissions paid	(c) Amount	1 003 and other commission	(d) Purpose	(e) Organization code	
Commissions paid	(o) / anount		(±). 3.5000		
				1	

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Part II		Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a uthis report.							
4	Curre	nt value of plan's interest under this contract in the general account at year	end		4				
_		nt value of plan's interest under this contract in separate accounts at year e			. 5				
6	Contr	acts With Allocated Funds:							
	а	State the basis of premium rates							
		Premiums paid to carrier			6b				
		Premiums due but unpaid at the end of the year			. 6c				
		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	d annuity						
		(3) other (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan che	ck here					
7		acts With Unallocated Funds (Do not include portions of these contracts ma							
			ate participation	,					
	-			<b>3</b>					
		(3) guaranteed investment (4) other							
	b	Balance at the end of the previous year			7b				
		Additions: (1) Contributions deposited during the year			1 10				
		(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)						
	ı								
					7-(0)				
	_	(6)Total additions			7c(6)	0			
		otal of balance and additions (add <b>b</b> and <b>c(6)</b> ).			. 7d				
		Deductions:	70/4						
	,	(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)						
	١	•							
	(	5) Total deductions			. 7e(5)	0			
	,	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			. 7f				

Page <b>4</b>	
mployer(s) or members of the same en perience-rated as a unit. Where contra- as a unit for purposes of this report.	
c X Vision g ☐ Supplemental unemployment k ☐ PPO contract	d ☐ Life insurance h ☐ Prescription drug l ☐ Indemnity contract

		If more than one contract covers the same gi information may be combined for reporting pothe entire group of such individual contracts of the entire group of such individual contracts of the same group.	urposes if such contracts a	are experienc	ce-rated as a unit. Whe	ere contract	
8	Bene	efit 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 disabilit	у <b>g</b> [	Supplemental unemp	loyment	<b>h</b> Prescription drug
	i [	Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Expe	erience-rated contracts:					
	•	Premiums: (1) Amount received		9a(1)		118674	
		(2) Increase (decrease) in amount due but unpaid	•	` '			-
		(3) Increase (decrease) in unearned premium res		• • •			
		(4) Earned ((1) + (2) - (3))				9a(4)	118674
	b	Benefit charges (1) Claims paid		9b(1)		99462	
		(2) Increase (decrease) in claim reserves		9b(2)		397	
		(3) Incurred claims (add (1) and (2))				9b(3)	99859
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (c	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)		20459	
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies.		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)	T		
		(H) Total retention	_	_	•	9c(1)(H)	20459
		(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 I	penefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	24865
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in <b>c(2)</b> .)		9e	
10	No	nexperience-rated contracts:			r		
	_	Total premiums or subscription charges paid to o				10a	
	b	If the carrier, service, or other organization incurretention of the contract or policy, other than rep	, .		•	10b	
	Sp	pecify nature of costs					

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

Schedule A (Form 5500) 2011

Part III

**Welfare Benefit Contract Information** 

<sup>12</sup> If the answer to line 11 is "Yes," specify the information not provided.

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

OMB No. 1210-0110

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					This Fo	rm is Open to Public Inspection	
For calendar plan year 20	11 or fiscal pla	an year beginning 02/01/201	1	and en	nding 01/3	1/2012	
A Name of plan AFFILIATED ASSOCIATION	ONS OF AME	ERICA HEALTH CARE TRUST			e-digit number (PN)	•	501
C Plan sponsor's name a				<b>D</b> Emplo	oyer Identificat 50245	tion Number	(EIN)
		rning Insurance Contrac Individual contracts grouped a					
(a) Name of insurance ca							
			(e) Approximate n	umber of		Policy or c	ontract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	t end of	(f) F	rom	<b>(g)</b> To
91-0621480	47341	504-508,599,701	36.	3621 02/01		1	01/31/2012
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, b	orokers, and	other persons in
		nmissions paid		<b>(b)</b> To	otal amount of	fees paid	
		0					0
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees v	vere paid	
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	e		(e) Organization code
	(a) Nama	and address of the agent, broke	or or other person to who	m commice	ione or foos w	voro poid	
	(a) Ivaille	and address of the agent, broke	er, or other person to who	III COIIIIII55	SIONS OF 1662 W	vere paid	
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

Schedule A (Form 5500)	2011	Page <b>2 -</b> 1	]		
	ame and address of the agent, broke	r. or other person to whom o	commissions or fees were paid		
(4)	and address of the agont, siene	., c. carer percent to innern			
(L) A		Fees and other commission	s paid	(-) ()	
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code	
•	, ,				
<b>(a)</b> Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid		
(b) Amount of sales and base		Fees and other commission	s paid	(e) Organization	
commissions paid	(c) Amount		(d) Purpose	code	
<b>(a)</b> Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid		
	I			T	
(b) Amount of sales and base		Fees and other commission		(e) Organization	
commissions paid	(c) Amount		(d) Purpose	code	
(a) Na	ame and address of the agent, broke	r or other person to whom o	commissions or fees were paid		
(a) (ve	and address of the agent, broke	r, or other person to whom t	commissions of fees were paid		
	I				
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commission	s paid (d) Purpose	(e) Organization	
commissions paid	(c) Amount		(d) Fulpose	code	
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid		
		, ,	•		
		Fees and other commission	naid	T.,	
(b) Amount of sales and base commissions paid	(c) Amount	1 003 and other commission	(d) Purpose	(e) Organization code	
Commissions paid	(o) / anount		(±). 3.5000		
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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts	with each carrier mag	y be treated	d as a unit for purposes of				
4	Curre	nt value of plan's interest under this contract in the general account at year	end		4					
_		Current value of plan's interest under this contract in separate accounts at year end								
6	Contr	Contracts With Allocated Funds:								
	а	State the basis of premium rates								
		Premiums paid to carrier			6b					
		Premiums due but unpaid at the end of the year			. 6c					
		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	d annuity							
		(3) other (specify)								
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan che	ck here						
7		acts With Unallocated Funds (Do not include portions of these contracts ma								
			ate participation	,						
	-			<b>3</b>						
		(3) guaranteed investment (4) other								
	b	Balance at the end of the previous year			7b					
		Additions: (1) Contributions deposited during the year			1 10					
		(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)							
	ı									
					7-(0)					
	_	(6)Total additions			7c(6)	0				
		otal of balance and additions (add <b>b</b> and <b>c(6)</b> ).			. 7d					
		Deductions:	70/4							
	,	(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)							
	١	•								
	(	5) Total deductions			. 7e(5)	0				
	,	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			. 7f					

Schedule A (Form 5500) 2011	Page <b>4</b>	
Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such contract the entire group of such individual contracts with each carrier may be	e same employer(s) or members of the same employee organizations(s), ts are experience-rated as a unit. Where contracts cover individual emploe treated as a unit for purposes of this report.	the yees,
efit and contract type (check all applicable boxes)		
Health (other than dental or vision)	<b>c</b> Vision	
Temporary disability (accident and sickness) <b>f</b> Long-term disa	oility $\mathbf{g} \square$ Supplemental unemployment $\mathbf{h} \square$ Prescription drug	
Stop loss (large deductible) j HMO contract	k PPO contract I I Indemnity contract	t
Other (specify)		
erience-rated contracts:		
Premiums: (1) Amount received	<b>9a(1)</b> 2880383	
(2) Increase (decrease) in amount due but unpaid	9a(2)	
(3) Increase (decrease) in unearned premium reserve	9a(3)	
(4) Earned ((1) + (2) - (3))		880383
Benefit charges (1) Claims paid	<b>9b(1)</b> 2426743	
(2) Increase (decrease) in claim reserves	<b>9b(2)</b> -58000	
(3) Incurred claims (add (1) and (2))		368743
(4) Claims charged		
Remainder of premium: (1) Retention charges (on an accrual basis)		
(A) Commissions	9c(1)(A)	

224670

9c(1)(H)

9c(2)

9d(1)

9d(2)

9d(3)

9e

10a

10b

224670

112000

retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

a Health (other than dental or vision)

Experience-rated contracts:

Benefit and contract type (check all applicable boxes)

Part III

a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid.....

(B) Administrative service or other fees .....

(C) Other specific acquisition costs..... (D) Other expenses.....

(E) Taxes..... (F) Charges for risks or other contingencies .....

(H) Total retention .....

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

(2) Claim reserves

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

Total premiums or subscription charges paid to carrier ...... If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

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

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

9c(1)(B)

9c(1)(C)

9c(1)(D) 9c(1)(E)

9c(1)(F)

<sup>12</sup> If the answer to line 11 is "Yes," specify the information not provided.

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation Service Provider Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2011

This Form is Open to Public Inspection.

For calendar plan year 2011 or fiscal plan year beginning 02/01/2011	and ending 01/31/2012			
A Name of plan AFFILIATED ASSOCIATIONS OF AMERICA HEALTH CARE TRUST	B Three-digit 501 plan number (PN) ▶			
C Plan sponsor's name as shown on line 2a of Form 5500 AFFILIATED ASSOCIATIONS OF AMERICA	D Employer Identification Number (EIN) 20-1050245			
Part I Service Provider Information (see instructions)				
You must complete this Part, in accordance with the instructions, to report the information or more in total compensation (i.e., money or anything else of monetary value) in complan during the plan year. If a person received <b>only</b> eligible indirect compensation answer line 1 but are not required to include that person when completing the remaindent of the property of the plan year.	connection with services rendered to the plan or the person's position with the a for which the plan received the required disclosures, you are required to ainder of this Part.			
1 Information on Persons Receiving Only Eligible Indirect Com	-			
a Check "Yes" or "No" to indicate whether you are excluding a person from the rema indirect compensation for which the plan received the required disclosures (see ins				
<b>b</b> If you answered line 1a "Yes," enter the name and EIN or address of each persor received only eligible indirect compensation. Complete as many entries as needed				
(b) Enter name and EIN or address of person who provide	ed you disclosures on eligible indirect compensation			
(b) Enter name and EIN or address of person who provid				
(b) Enter name and EIN or address of person who provide	ed you disclosures on eligible indirect compensation			
42-				
(b) Enter name and EIN or address of person who provide	ed you disclosures on eligible indirect compensation			

Page <b>3 -</b> 1	

answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ich person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in	total compensation
			a) Enter name and EIN or	address (see instructions)		
AFFILIATE	D SERVICES LLC		10510 NE	NORTHUP WAY, SUITE 200 D, WA 98033		
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	
13		1711120	Yes No 🗵	Yes No 🗵	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
AFFILIATE 20-5539612	D SERVICES LLC			E NORTHUP WAY, SUITE 200 ND, WA 98033		
(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		748279	Yes No X	Yes No 🗵	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
BILL YEAG	ER			48TH AVE W SUITE 350 DOD, WA 98037		
53-1445244	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		54175	Yes No X	Yes No X	0	Yes No X

Page :	3 -	2
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answered	d "Yes" to line 1a abov	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and EIN or	address (see instructions)		
WASHING	TON DENTISTS INSU		1001 - 4T	H AVE 3800 E, WA 98154		
91-149926	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?
22		49805	Yes No X	Yes No X	0	Yes No X
			(a) Enter name and EIN or	address (see instructions)		
KIBBLE &	PRENTICE			ON ST., 1000 E, WA 98101		
91-117631		T				
(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	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		47853	Yes No 🗵	Yes No 🗵	0	Yes No X
			(a) Enter name and EIN or	address (see instructions)		
MCM				TH AVE SUITE 2100 E, WA 98101		
91-085188	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		30880	Yes No X	Yes No X	0	Yes No X

Page	3 -	3
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answered	d "Yes" to line 1a abov	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and EIN or	address (see instructions)		
OLYMPIC	CREST INSURANCE		PO BOX 2			
91-171757	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		22484	Yes No 🗵	Yes No X	0	Yes No X
			(a) Enter name and EIN or	address (see instructions)	,	
RHD EMPI	LOYEE BENEFITS		PO BOX			
91-195649 (b) Service	(c) Relationship to	(d) Enter direct	(e) Did service provider	(f) Did indirect compensation	<b>(g)</b> Enter total indirect	(h) Did the service
Code(s)	employer, employee organization, or person known to be a party-in-interest		receive indirect compensation? (sources other than plan or plan sponsor)	include eligible indirect compensation, for which the plan received the required disclosures?	compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	provider give you a formula instead of an amount or estimated amount?
22		15993	Yes No X	Yes No 🗵	0	Yes No X
			(a) Enter name and EIN or	address (see instructions)		
MADDOCK	( AND ASSOCIATES		` '	AVE MADDOCK 1407 WILLOW	ROAD	
91-128040	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		12981	Yes No X	Yes No X	0	Yes No X

Page	3	-	4
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Schedule C (	Form 5500	2011 (
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-	Schedule C (Form 550	00) 2011		Page <b>3 -</b> 4		
answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ach 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)		
SMITHSON	N INSURANCE SERVI	ICES		EY MALL PARKWAY ENATCHEE, WA 98802		
53-758937	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?
22		12217	Yes No 🛚	Yes No 🗵	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
ADVISOR I				CLEARWATER SUITE 100 VICK, WA 99336		
91-1628862	1	T			T	ı
(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		11990	Yes No 🛚	Yes No 🗵	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
HUB INTER	RNATIONAL NW LLC		PO BOX BOTHEL	3018 L, WA 98041		
91-203601	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?	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						

Page	3 -	5
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answered	d "Yes" to line 1a abov	e, complete as many	entries as needed to list ea	or Indirect Compensation ach 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)		
GREEN FI	NANCIAL	<u> </u>	PO BOX			
91-135521	4					
(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		11335	Yes No X	Yes No X	0	Yes No X
			(a) Enter name and EIN or	address (see instructions)		
GALLAGH	ER BENEFITS SERVI			BTH AVE NE		
36-429197 <b>(b)</b>	1 <b>(c)</b>	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none, enter -0		Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	Did the service provider give you a formula instead of an amount or estimated amount?
22		10610	Yes No X	Yes No X	0	Yes No X
			(a) Enter name and EIN or	address (see instructions)	,	
LINDHE IN	ISURANCE		106 EAS	T MAIN STREET NDALE, WA 98620		
91-153795	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		10347	Yes No X	Yes No X	0	Yes No X

Page	3 -	6
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Schedule C (	Form 5500	2011 (
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answered	l "Yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ach 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)		
ALEX SKO	ULIS		PO BOX SEATTLE	15852 :, WA 98115		
30-1725354	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		9517	Yes No X	Yes No X	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
91-142849	AST INSURANCE		PO BOX VANCOL	189 JVER, WA 98666		
(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		9264	Yes No X	Yes No X	0	Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
AUTOMOT 91-1409840	IVE BENEFITS CORF	PORATION	PO BOX MILL CR	13170 EEK, WA 98082		
(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		8416	Yes No X	Yes No X	0	Yes No X

Page	3	-	7
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	Schedule C (Form 550	00) 2011		Page <b>3 -</b> 7		
answered	f "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation in the 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)		
HEALTHY	FAMILY INSURANCE	LLC	16706 E ( ELK, WA	DREGON RD 99009		
53-750451	6					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22		7231	Yes No 🗵	Yes No 🗵	0	Yes No X
		(	(a) Enter name and EIN or	address (see instructions)		
COMPASS	CONSULTING			ST AVE S STE 322 E, WA 98134		
91-208934	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		6975	Yes No X	Yes No 🗵	0	Yes No X
		(	(a) Enter name and EIN or	address (see instructions)		
ETHIX NOI	RTHWEST			TH ST NW, 107 RBOR, WA 98335		
13-428358	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?	(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		6218	Yes No X	Yes No X	0	Yes No X

Page	3 -	8
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answered	d "Yes" to line 1a abov	e, complete as many	entries as needed to list ea	or Indirect Compensation the person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and EIN or	address (see instructions)		
WALLING	FORD FINANCIAL SE	·	236 SE 17	,		
71-090708	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		6178	Yes No X	Yes No X	0	Yes No X
			(a) Enter name and EIN or	address (see instructions)		
HEFFERN	AN INSURANCE BRO	KERS	PO BOX	39038 ND, OR 97239		
94-250609			,			
(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		6050	Yes No 🗵	Yes No 🗵	0	Yes No X
			(a) Enter name and EIN or	address (see instructions)	,	
CATHY ME	ERZ INSURANCE INC			/ WESTDALE DR ND, OR 97221		
27-300951	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		5426	Yes No X	Yes No X	0	Yes No X

## Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compens or provides contract administrator, consulting, custodial, investment advisory, investment ma questions for (a) each source from whom the service provider received \$1,000 or more in inc provider gave you a formula used to determine the indirect compensation instead of an amount many entries as needed to report the required information for each source.	nagement, broker, or recordkeepinç direct compensation and (b) each so	g services, answer the following ource for whom the service			
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect			
	(see instructions)	compensation			
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibilit for or the amount of 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	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligib for or the amount of 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	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.				

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

Page	6-
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Pa	rt III	Termination Information on Accountants and Enrolled Actuaries (see insection) (complete as many entries as needed)	structions)
а	Name		b ein:
С	Positio	n:	
d	Addres	es:	e Telephone:
Ex	olanatio	1:	
а	Name:		b EIN:
C	Positio		
d	Addres		<b>e</b> Telephone:
Exp	olanatio	n:	
а	Name:		<b>b</b> EIN:
С	Positio		
d	Addres		e Telephone:
Ex	olanatio	n:	
а	Name:		b EIN:
C	Positio		
d	Addres		e Telephone:
Ex	olanatio	n:	
а	Name:		b EIN:
C	Positio	n:	
d	Addres		<b>e</b> Telephone:
Ex	planatio	1:	

### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### 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), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with

OMB Nos. 1210 - 0110 1210 - 0689

2011

Pension Benefit Guaranty Corporation the instructions to the Form 5500.				This Form is Open to Public Inspection			
Part I Annual Report Identification Information							
For calendar plan year 2011 or fiscal plan year beginning 02/01/2011 and ending 01/31/2012							
A This return/report is for:	a multiemployer pl	an;	X ami	ultiple-employer pla	in; or	***************************************	
	a single-employer	plan;	a DF	E (specify)			
B This return/report is:	the first return/rep	ort;	the	final return/report;			
	an amended return			ort plan year return	n/report (less t	han 12 months)	
C If the plan is a collectively-ba		e					
D Check box if filing under:	Form 5558;		auto	matic extension;	the [	DFVC program;	
Posis Blan In	special extension						
	formation - enter all r	equested information		T			
1a Name of plan AFFILIATED ASSOCI	TATTONS OF A	MERICA HEAL	mu .	1b Three-digit plan number		501	
CARE TRUST	IAIIONS OF A	MENT CA IIIME	1.11	<u> </u>		301	
CARD TROOT					Effective date of plan 02/01/2007		
2a Plan sponsor's name and address, including room or suite number (Employer, if for a single-employer plan)				2b Employer Identification Number (EIN) 20-1050245			
AFFILIATED ASSOCIATIONS OF AMERICA			2c Sponsor's telephone number				
				Od Divisionana	-d- ( in-t-		
P.O. BOX 3265				2d Business code (see instructions) 525100			
1.0. 2011 3203							
KIRKLAND	WA	98033					
10510 NE NORTHUP	WAY, SUITE	200					
	,						
KIRKLAND	WA	98033					
Caution: A penalty for the late of	or incomplete filing of t	his return/report will	be assessed unless re	asonable cause is	established.		
Under penalties of perjury and other penalties as the electronic version of this return/report				mpanying schedules, stat	tements and attach	ments, as well	
	018						
SIGN HERE		11/14/12	PATRICK A C				
Signature of plan admin	istrator	Date	Enter name of individua	al signing as plan a	dministrator		
SIGN. HERE aby	1 ahril	11/14/12	PROPERE A. CHESONIUS				
Signature of employer/p	olan sponsor	Date	Enter name of individua			onsor	
SIGN							
HERE Signature of DFE		Date	Enter name of individua	al signing as DFE			
For Panarwork Poduction Act N	lotice and OMB Contro	l illumbare eas the i			For	m 5500 (2011)	

V.012611

For	Form 5500 (2011) Page <b>2</b>									
	3a Plan administrator's name and address (if same as plan sponsor, enter "Same") SAME			rator's	ator's EIN					
					3	3c Administ	rator's	telephone	number	
4	If the name and/or EIN of the plan sponsor has changed since the last EIN and the plan number from the last return/report:	return/repo	rt f	iled for thi	s plan,	enter the nar	ne,	4b EIN		
а	Sponsor's name					<b>4c</b> PN				
5	Total number of participants at the beginning of the plan year						5		8,444	
6	Number of participants as of the end of the plan year (welfare plans co									
a	Active participants						6a		6,634	
C	Retired or separated participants receiving benefits  Other retired or separated participants entitled to future benefits						6b		16	
d	Subtotal. Add lines <b>6a, 6b,</b> and <b>6c</b>				• • • • • • • • • • • • • • • • • • • •		6c 6d		137 6,787	
е	Deceased participants whose beneficiaries are receiving or are entitled	I to receive I	 oer	efits			6e		0,707	
f	Total. Add lines <b>6d</b> and <b>6e</b>						6f			
g	g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).									
h	Number of participants that terminated employment during the plan ye									
_	100% vested						6h			
7	Enter the total number of employers obligated to contribute to the plan						_			
8a	complete this item)		<u></u>	Al 1 3-4		·····	7			
b	If the plan provides welfare benefits, enter the applicable welfare featur $4B\ 4D\ 4E$									
9a	Plan funding arrangement (check all that apply)				gemen	t (check all th	at app	ly)		
	(1) X Insurance	(1)	X							
	(2) Code section 412(e)(3) insurance contracts	(2)	Н		ection 4	112(e)(3) insu	rance c	ontracts		
	(3) Trust (4) General assets of the sponsor	(3)	Н	Trust		*				
10	(4)   General assets of the sponsor  Check all applicable boxes in 10a and 10b to indicate which schedules (See instructions)	are attache	d, ;			of the spons ated, enter th		oer attach	ed.	
а	Pension Schedules	b Gen	era	ıl Schedu	les					
-	(1) R (Retirement Plan Information)	(1)	П			Financial Info	rmatio	n)		
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money		H		,	Financial Info		•	lan)	
	Purchase Plan Actuarial Information) - signed by the plan	(3)	X	_ 4	,		ce Information)			
	actuary	(4)	X			Service Provi		,		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)				DFE/Participa		,	ation)	
	Information) - signed by the plan actuary	(6)	Ш		<b>G</b> (	Financial Trar	sactio	n Schedul	es)	