### 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), 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

2012

This Form is Open to Public Inspection

						inspection	
Part I	Annual Report Identific						
For caler	ndar plan year 2012 or fiscal plan y				31/2013		
A This r	eturn/report is for:	a multiemployer plan;	님 :	e-employer plan; or			
		a single-employer plan;	a DFE (s	pecify)			
<b>B</b> This r	eturn/report is:	the first return/report;	the final i	return/report;			
		an amended return/report;	a short p	lan year return/report (les	ss than 12 m	onths).	
C If the	plan is a collectively-bargained pla	an, check here				<b>→</b> □	
<b>D</b> Chec	k box if filing under:	Form 5558;	automati	c extension;	th	e DFVC program;	
	<b>3</b>	special extension (enter desc	cription)		ш		
Part l	I Basic Plan Information	on—enter all requested informa	. ,				
	e of plan	onto an requested informa	alon e		1b	Three-digit plan	
	TED ASSOCIATIONS OF AMERIC	CA HEALTH CARE TRUST				number (PN) ▶	501
					1c	Effective date of pl	an
0- 5					Ol-	02/01/2007	
<b>2a</b> Plan	sponsor's name and address; inc	lude room or suite number (emp	loyer, if for a single-	employer plan)	20	Employer Identifica Number (EIN)	ation
AFFII IA	TED ASSOCIATIONS OF AMERI	CA				20-1050245	
7.11.1.2.11					2c	Sponsor's telephor	ne
						number	
P.O. BO			NORTHUP WAY, S	UITE 200	24	Dusiness ands (se	
KIRKLAN	ND, WA 98033	KIRKLANE	D, WA 98033		Zu	Business code (se instructions)	е
						525100	
Caution	A penalty for the late or incom	nlete filing of this return/renor	t will he assessed	unless reasonable caus	sa is astabli	shad	
	enalties of perjury and other penal						edules
	its and attachments, as well as the						
SIGN	Filed with authorized/valid electro	nic signature.	11/15/2013	PATRICK A CHESTN	UT		
HERE	Signature of plan administrato	r	Date	Enter name of individu	al signing as	plan administrator	
					J		
SIGN							
HERE	Signature of employer/plan sp	onsor	Date	Enter name of individu	al signing as	employer or plan sp	onsor
	orginature or employer/plan sp	Onsor	Dute	Enter name of marriad	ar orgining ao	ciripioyer or plan op	7011001
SIGN							
HERE	Signature of DFE		Date	Enter name of individu	al aigning an	DEE	
Preparer	's name (including firm name, if ap	oplicable) and address; include re				telephone number	
	N CLARK	, ,		,	(optional)	405 004 0500	
CLARK,	RAYMOND & COMPANY, PLLC					425-861-8500	
P.O. BO	X 3188						
	ND, WA 98073-3188						

Form 5500 (2012) Page **2** 

3a	Plan administrator's name and address Same as Plan Sponsor Name	Same as Plan Sponsor Address	<b>3b</b> Administrator's EIN			
			3c Administrator's telephone number			
4	If the name and/or EIN of the plan sponsor has changed since the last return EIN and the plan number from the last return/report:	n/report filed for this plan, enter the name,	4b EIN			
а	Sponsor's name		4c PN			
5	Total number of participants at the beginning of the plan year		<b>5</b> 6787			
6	Number of participants as of the end of the plan year (welfare plans complet	te only lines <b>6a, 6b, 6c,</b> and <b>6d</b> ).				
а	Active participants		. <b>6a</b> 3519			
b	Retired or separated participants receiving benefits		. <b>6b</b> 26			
С	Other retired or separated participants entitled to future benefits		. <b>6c</b> 0			
d	Subtotal. Add lines 6a, 6b, and 6c.		. <b>6d</b> 3545			
е	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive benefits	. 6e			
f	Total. Add lines 6d and 6e		. 6f			
g	Number of participants with account balances as of the end of the plan year complete this item)		. 6g			
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 plans complete this item)	7			
	8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:  b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  4A 4B 4D 4E					
		I				
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that (1) Insurance	at apply)			
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) X Insurance Code section 412(e)(3)	insurance contracts			
	(3) Trust	(3) Trust	modranes sermane			
	(4) General assets of the sponsor	(4) General assets of the sp	oonsor			
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, where indicated, enter the number	ber attached. (See instructions)			
а	Pension Schedules	b General Schedules				
-	(1) R (Retirement Plan Information)	П	mation)			
	—					
	MB (Multiemployer Defined Benefit Plan and Certain Money	` '	nation – Small Plan)			
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3) X 4 A (Insurance Infor				
	· —	(4) C (Service Provide				
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	· · · · · · · · · · · · · · · · · · ·	ng Plan Information)			
	Information) - signed by the plan actuary	(6) G (Financial Trans	saction Schedules)			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

nurought to EDICA coation 400(a)(0)					m is Open to Public Inspection		
For calendar plan year 2012 or fiscal plan year beginning 02/01/2012 and ending 01/31/2013							
A Name of plan AFFILIATED ASSOCIATION	ONS OF AME	RICA HEALTH CARE TRUST			e-digit number (PN	J) •	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						EIN)	
		ning Insurance Contract . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
UNIMERICA INSURANC	E COMPANY						
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			•	ontract year I
(5) EIIV	code	identification number	policy or contrac		(f)	From	<b>(g)</b> To
36-2739571	91529	666	35	19	05/01/201	12	04/30/2013
2 Insurance fee and composite descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, I	brokers, and o	ther 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	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees	were paid	
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees	were paid	
	(4)	and dadrees or the agent, show	., o. oo. porocii to iiiio	σσ		paia	
(b) Amount of sales ar	nd base		ees and other commissio	ns paid			
commissions pai	d	(c) Amount	(d) Purpose				(e) Organization code

Schedule A (Form 5500)	2012	Page <b>2 -</b> 1						
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
	,	.,,						
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
( ) ) !			• • • • • • • • • • • • • • • • • • • •					
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
	T		<u> </u>					
(b) Amount of sales and base	(-) A	Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
	, , , , , , , , , , , , , , , , , , ,							
(h) Amount of color and bose		Fees and other commissions paid	(2) Orner in eties					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code					
•	, ,							
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					

		•
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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 unit for purposes of					
_		this report.					
		nt value of plan's interest under this contract in the general account at year					
_		nt value of plan's interest under this contract in separate accounts at year e	nd		5		
ь		acts With Allocated Funds:					
	а	State the basis of premium rates					
	<b>L</b>	Describeration and the country			Ch		
		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					
	e	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 d	heck here			
7		acts With Unallocated Funds (Do not include portions of these contracts ma					
•				ion guarantee			
	u			.o guarantos			
		(3) guaranteed investment (4) other					
	b	Balance at the end of the previous year			7b		
		Additions: (1) Contributions deposited during the year	. 7c(1)				
		(2) Dividends and credits	7c(2)				
		(3) Interest credited during the year	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	. 7c(5)				
	)						
		(C) Total additions			7c(6)	0	
	_	(6)Total additions			76(6)		
		otal of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )	Γ		/u		
		Disbursed from fund to pay benefits or purchase annuities during year	7e(1)				
		Administration charge made by carrier	7e(1)				
		3) Transferred to separate account	7e(2)				
	`	4) Other (specify below)	7e(3)				
	(	T) Outor (specify below)	, 5(7)				
	ļ	•					
	(	5) Total deductions			7e(5)	0	
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			7f		

					_		
		Schedule A (Form 5500) 2012		Pag	ge <b>4</b>		
Pa	rt II	Welfare Benefit Contract Information If more than one contract covers the same guinformation may be combined for reporting pothe entire group of such individual contracts of the same group of the same group of such individual contracts of the same group of the same	roup of employees of the surposes if such contracts	are experienc	e-rated as a unit. Wh	ere contrac	
8	Ben	efit and contract type (check all applicable boxes)	_				_
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty <b>g</b>	Supplemental unemp	oloyment	<b>h</b> Prescription drug
	i [	Stop loss (large deductible)	j HMO contract	k	PPO contract		I ndemnity contract
	m	Other (specify)	, n		I.		<u> </u>
	[						
9	Ехр	erience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	d	9a(2)			
		(3) Increase (decrease) in unearned premium res				1	
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)		01 (0)	
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (c	,	0-(4)(A)			_
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)			-
		(C) Other specific acquisition costs(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					
		(H) Total retention	· ·			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	_	_			
	d	Status of policyholder reserves at end of year: (1				9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2).	)	9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to o	carrier			10a	

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

10b

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, line 2 above, report amount......

Specify nature of costs

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

nurought to EDICA agotion 402(a)(2)					m is Open to Public Inspection		
For calendar plan year 2012 or fiscal plan year beginning 02/01/2012 and ending 01/31/2013							
A Name of plan AFFILIATED ASSOCIATION	ONS OF AME	RICA HEALTH CARE TRUST			e-digit number (PN	J) <b>•</b>	501
C Plan sponsor's name a AFFILIATED ASSOCIATION				<b>D</b> Emplo 20-105		ation Number	(EIN)
		rning Insurance Contract Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
UNITED HEALTHCARE I	NSURANCE	COMPANY					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			•	ontract year
(b) LIN	code	identification number	policy or contract		(f)	From	<b>(g)</b> To
36-2739571	79413	301705	351	19	05/01/201	12	04/30/2013
2 Insurance fee and composite descending order of the		nation. Enter the total fees and $\mathfrak{t}$	otal commissions paid. Li	ist in line 3	the agents, I	brokers, and o	ther 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	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to whor	m commissi	ions or fees	were paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees	were paid	
	(4)	and address of the agent, siend	, 6. 66. регоси се ппе				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
Commissions pala (C) Amount (a) Fulpose (e) (							

Schedule A (Form 5500)	2012	Page <b>2 -</b> 1						
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
	,	.,,						
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
( ) ) !			• • • • • • • • • • • • • • • • • • • •					
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
	T		<u> </u>					
(b) Amount of sales and base	(-) A	Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
	, , , , , , , , , , , , , , , , , , ,							
(h) Amount of color and bose		Fees and other commissions paid	(2) Orner institut					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code					
•	, ,							
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					

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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 unit for purposes of					
_		this report.					
		nt value of plan's interest under this contract in the general account at year					
_		nt value of plan's interest under this contract in separate accounts at year e	nd		5		
ь		acts With Allocated Funds:					
	а	State the basis of premium rates					
	<b>L</b>	Describeration and the country			Ch		
		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					
	e	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 d	heck here			
7		acts With Unallocated Funds (Do not include portions of these contracts ma					
•				ion guarantee			
	u			.o guarantos			
		(3) guaranteed investment (4) other					
	b	Balance at the end of the previous year			7b		
		Additions: (1) Contributions deposited during the year	. 7c(1)				
		(2) Dividends and credits	7c(2)				
		(3) Interest credited during the year	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	. 7c(5)				
	)						
		(C) Total additions			7c(6)	0	
	_	(6)Total additions			76(6)		
		otal of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )	Γ		/u		
		Disbursed from fund to pay benefits or purchase annuities during year	7e(1)				
		Administration charge made by carrier	7e(1)				
		3) Transferred to separate account	7e(2)				
	`	4) Other (specify below)	7e(3)				
	(	T) Outor (specify below)	, 5(7)				
	ļ	•					
	(	5) Total deductions			7e(5)	0	
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			7f		

		Schedule A (Form 5500) 2012		Pa	age <b>4</b>		
Par	t III	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts of	oup of employees of the surposes if such contracts a	are experien	ce-rated as a unit. Wh	ere contract	
<b>8</b> B	enefit	and contract type (check all applicable boxes)					
a	_	Health (other than dental or vision)	<b>b</b> Dental	сГ	Vision		<b>d</b> X Life insurance
e		Femporary disability (accident and sickness)	f Long-term disabilit	y <b>g</b>	Supplemental unem		h Prescription drug
·	片	Stop loss (large deductible)	j HMO contract	, s∟ k[	PPO contract	oloyillolli	I Indemnity contract
			I I I I I I I I I I I I I I I I I I I	٨L	] FFO contract		
r	n 📋 (	Other (specify)					
9 E	vnorio	nce-rated contracts:					
	•	miums: (1) Amount received	]	9a(1)			
·		Increase (decrease) in amount due but unpaid	ŀ	9a(2)			
	. ,	Increase (decrease) in unearned premium res		9a(3)			
	` '	Earned ((1) + (2) - (3))				9a(4)	
	. ' ′	enefit charges (1) Claims paid	Ī	9b(1)			
	(2)	Increase (decrease) in claim reserves		9b(2)			
		Incurred claims (add (1) and (2))				9b(3)	
	(4)	Claims charged				9b(4)	
(	C Re	emainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies.	•	9c(1)(F)			
		(G) Other retention charges	•			I	
		(H) Total retention	_			9c(1)(H)	
	(2)	Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
(	<b>d</b> St	atus of policyholder reserves at end of year: (1	) Amount held to provide I	benefits afte	r retirement	9d(1)	
	(2)	Claim reserves				9d(2)	
	` '	Other reserves				9d(3)	
(		vidends or retroactive rate refunds due. (Do n	ot include amount entered	l in line <b>9c(2</b> )	).)	9e	
10	None	operience-rated contracts:					

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

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

10a

10b

Specify nature of costs

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

nursuant to EDICA continu (102/a)/2)					m is Open to Public Inspection		
For calendar plan year 20	12 or fiscal pla	an year beginning 02/01/2012	2	and end	ling 01/31/2		
A Name of plan AFFILIATED ASSOCIATION	ONS OF AME	RICA HEALTH CARE TRUST		B Three plan r	-digit number (PN)	<b>)</b>	501
C Plan sponsor's name a AFFILIATED ASSOCIATION				<b>D</b> Employ 20-1050	ver Identification 0245	Number (	EIN)
on a separat		rning Insurance Contract Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
VISION SERVICE PLAN			(a) Approximate nu	mhor of		oliov or oc	entract voor
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered at policy or contract	end of	(f) Fror	•	ontract year (g) To
91-6056925	47317	12256001	351	9	07/01/2012		06/30/2013
2 Insurance fee and composite descending order of the		nation. Enter the total fees and t	otal commissions paid. Lis	st in line 3 th	he agents, broke	ers, and ot	ther persons in
(a) Total a	mount of cor	nmissions paid		<b>(b)</b> Tot	al amount of fee	es paid	
		0					0
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all p	ersons).			
	(a) Name	and address of the agent, broke	er, or other person to whon	n commissio	ons or fees were	paid	
(b) Amount of sales ar	nd base	F	ees and other commission	s paid			
commissions pai	d	(c) Amount	(d) Purpose				(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to whon	n commissio	ons or fees were	naid	
	(4)	and address of the agent, stone	, or care, percent to micro			ран	
(b) Amount of sales and base Fees and other commission				s paid			
commissions pai	d	(c) Amount	(	(d) Purpose			(e) Organization code

Schedule A (Form 5500)	2012	Page <b>2 -</b> 1	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
	,	.,,	
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
( ) ) !			• • • • • • • • • • • • • • • • • • • •
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
	T		<u> </u>
(b) Amount of sales and base	(-) A	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
	, , , , , , , , , , , , , , , , , , ,		
(h) Amount of color and bose		Fees and other commissions paid	(2) Orner in eties
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
•	, ,		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

		•
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ay		•

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 unit for purposes of						
_		this report.						
		nt value of plan's interest under this contract in the general account at year						
_		nt value of plan's interest under this contract in separate accounts at year e	nd		5			
ь		acts With Allocated Funds:						
	а	State the basis of premium rates						
	<b>L</b>	Describeration and the country			Ch			
		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						
	e	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 d	heck here				
7		acts With Unallocated Funds (Do not include portions of these contracts ma						
•				ion guarantee				
	u			.o guarantos				
		(3) guaranteed investment (4) other						
	b	Balance at the end of the previous year			7b			
		Additions: (1) Contributions deposited during the year	. 7c(1)					
		(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	. 7c(5)					
	)							
		(C) Total additions			7c(6)	0		
	_	(6)Total additions			76(6)			
		otal of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )	Γ		/u			
		Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		Administration charge made by carrier	7e(1)					
		3) Transferred to separate account	7e(2)					
	`	4) Other (specify below)	7e(3)					
	(	T) Outor (specify below)	, 5(7)					
	ļ	•						
	(	5) Total deductions			7e(5)	0		
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			7f			

Pa	age <b>4</b>		
e experien		ere contracts	loyee organizations(s), the cover individual employees,
c g k	Vision Supplemental unemp PPO contract		d Life insurance h Prescription drug l Indemnity contract
9a(1)		120478	
9a(1)		120470	
9a(3)			
		9a(4)	120478
9b(1)		96802	
9b(2)		-665	
		9b(3)	96137

Schedule A	(Form 550	0) 2012

Part								
	If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees,							
	the entire group of such individual contracts					over individual employees,		
<b>8</b> Be	nefit and contract type (check all applicable boxes)	•		· ·	•			
а	Health (other than dental or vision)	<b>b</b> Dental	c	Vision	d	Life insurance		
e			<u> </u>	<u></u>				
	Temporary disability (accident and sickness)		·	Supplemental unem	pioyment II			
ı	Stop loss (large deductible)	j   HMO contract	k _	PPO contract	וי	Indemnity contract		
m	Other (specify)							
	perience-rated contracts:		- 411					
а	Premiums: (1) Amount received				120478			
	(2) Increase (decrease) in amount due but unpai							
	(3) Increase (decrease) in unearned premium res				00(4)	120478		
b	(4) Earned ((1) + (2) - (3)) Benefit charges (1) Claims paid				9 <b>68</b> 02	120470		
D	(2) Increase (decrease) in claim reserves		:-:		-665			
	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)	96137		
	(4) Claims charged				9b(4)			
С	Remainder of premium: (1) Retention charges (c				02(1)			
	(A) Commissions		9c(1)(A)					
	(B) Administrative service or other fees				21084			
	(C) Other specific acquisition costs		- (1)(-)					
	(D) Other expenses		9c(1)(D)					
	(E) Taxes		9c(1)(E)					
	(F) Charges for risks or other contingencies.							
	(G) Other retention charges		9c(1)(G)					
	(H) Total retention	<u> </u>			9c(1)(H)	21084		
	(2) Dividends or retroactive rate refunds. (These	e amounts were paid	in cash, or	credited.)	9c(2)			
d	Status of policyholder reserves at end of year: (1	1) Amount held to provide	e benefits after	r retirement	. 9d(1)			
	(2) Claim reserves				. 9d(2)	24201		
	(3) Other reserves				. 9d(3)			
е		ot include amount entere	ed in line 9c(2)	.)	. 9e			
<b>10</b> N	onexperience-rated contracts:							
а	3				. 10a			
b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep	, ,		•	10b			
<b>c</b>	Specify nature of costs	oncuminanti, iiile 2 abu	wo, report allic	June	. 100			

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

<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.

Insurance companies are required to provide the information

OMB No. 1210-0110

nurought to FDICA continu 402(a)(2)					m is Open to Public Inspection		
For calendar plan year 20	12 or fiscal pla	an year beginning 02/01/2012	2	and en	ding 01/	31/2013	
A Name of plan AFFILIATED ASSOCIATION	ONS OF AME	RICA HEALTH CARE TRUST		<b>B</b> Three plan	e-digit number (PN	J) •	501
C Plan sponsor's name a				<b>D</b> Emplo 20-105		ation Number (	EIN)
		ning Insurance Contraction Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca							
WASHINGTON DENTAL	SERVICE						
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			•	ontract year
(-,	code	identification number	policy or contrac		(f)	From	<b>(g)</b> To
91-0621480	47341	504-508,599,701	403	4035 02/01/2012		12	01/31/2013
2 Insurance fee and come descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3 t	the agents, I	brokers, and o	ther persons in
(a) Total a	amount of con	nmissions paid		<b>(b)</b> To	tal amount o	of fees paid	
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 commissi	ions or fees	were paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees	were paid	
	(4)	and address of the agent, stone	.,			noro para	
(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500)	2012	Page <b>2 -</b> 1	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
	,	.,,	
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
( ) ) !			• • • • • • • • • • • • • • • • • • • •
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
	T		<u> </u>
(b) Amount of sales and base	(-) A	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
	, , , , , , , , , , , , , , , , , , ,		
(h) Amount of color and bose		Fees and other commissions paid	(2) Orner in eties
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
•	, ,		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

		•
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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 of		cts with each carrier ma	ay be treated	as a unit for purposes of				
_		this report.						
		nt value of plan's interest under this contract in the general account at year						
_		nt value of plan's interest under this contract in separate accounts at year e	nd		5			
ь		acts With Allocated Funds:						
	а	a State the basis of premium rates ▶						
	<b>L</b>	Describeration and the country			Ch			
		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						
	e	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 d	heck here				
7		acts With Unallocated Funds (Do not include portions of these contracts ma						
•				ion guarantee				
	u			.o guarantos				
		(3) guaranteed investment (4) other						
	b	Balance at the end of the previous year			7b			
		Additions: (1) Contributions deposited during the year	. 7c(1)					
		(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	. 7c(5)					
	)							
		(C) Total additions			7c(6)	0		
	_	(6)Total additions			76(6)			
		otal of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )	Γ		/u			
		Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		Administration charge made by carrier	7e(1)					
		3) Transferred to separate account	7e(2)					
	`	4) Other (specify below)	7e(3)					
	(	T) Outor (specify below)	, 5(7)					
	ļ	•						
	(	5) Total deductions			7e(5)	0		
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			7f			

Schedule A (Form 5500) 2012	Page <b>4</b>		
Malfana Banafit Occidental Information			
Welfare Benefit Contract Information  If more than one contract covers the same group of employe information may be combined for reporting purposes if such the entire group of such individual contracts with each carrie	contracts are experience-rated a	is a unit. Where contracts co	
and contract type (check all applicable boxes)			
ealth (other than dental or vision) <b>b</b> 🛛 Dental	<b>c</b> Vision	d	Life insurance
emporary disability (accident and sickness) $f f$ $\overline{igcap }$ Long-ter	rm disability $\mathbf{g}  \overline{\square}$ Suppler	mental unemployment <b>h</b>	Prescription drug
top loss (large deductible) j 📗 HMO co	ntract <b>k</b> PPO co	ntract I	Indemnity contract
Other (specify)			
nce-rated contracts:			
niums: (1) Amount received	9a(1)	2758085	
Increase (decrease) in amount due but unpaid	9a(2)		
Increase (decrease) in unearned premium reserve	9a(3)		
Earned ((1) + (2) - (3))		9a(4)	2758085
nefit charges (1) Claims paid	9b(1)	2334606	
Increase (decrease) in claim reserves	9b(2)	6000	
Incurred claims (add <b>(1)</b> and <b>(2)</b> )		9b(3)	2340606
Claims charged		9b(4)	
mainder of premium: (1) Retention charges (on an accrual ba	ısis)		
(A) Commissions	·		
		000004	

Benefit and contract type (check all applicable boxes) **b** X Dental a Health (other than dental or vision) Temporary disability (accident and sickness) Long-term disability Stop loss (large deductible) **HMO** contract Other (specify) Experience-rated contracts: a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid...... (3) Increase (decrease) in unearned premium reserve..... (4) Earned ((1) + (2) - (3)) ...... Benefit charges (1) Claims paid ..... (2) Increase (decrease) in claim reserves..... (3) Incurred claims (add (1) and (2)) ...... (4) Claims charged..... Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions..... (B) Administrative service or other fees ..... 9c(1)(B) (C) Other specific acquisition costs..... 9c(1)(C) (D) Other expenses..... 9c(1)(D) 9c(1)(E) (E) Taxes..... (F) Charges for risks or other contingencies ..... 9c(1)(F) (H) Total retention ..... 9c(1)(H) 228921 (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) 118000 (2) Claim reserves 9d(2) 9d(3) (3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... 9e **10** Nonexperience-rated contracts: 10a 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 10b retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify 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

Part III

<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

2012

This Form is Open to Public Inspection.

For calendar plan year 2012 or fiscal plan year beginning 02/01/2012	and ending 01/31/201	3
A Name of plan AFFILIATED ASSOCIATIONS OF AMERICA HEALTH CARE TRUST	<b>B</b> Three-digit plan number (PN)	501
C Plan sponsor's name as shown on line 2a of Form 5500	<b>D</b> Employer Identification N	lumber (EIN)
AFFILIATED ASSOCIATIONS OF AMERICA	20-1050245	
Part I Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the infor 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 remainder of the plan year.  Information on Persons Receiving Only Eligible Indirect Complete the plan year.	onnection with services rendered to the for which the plan received the required ainder of this Part.	plan or the person's position with the
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainderect compensation for which the plan received the required disclosures (see instance).	•	, , , , , , , , , , , , , , , , , , ,
<b>b</b> If you answered line 1a "Yes," enter the name and EIN or address of each person received only eligible indirect compensation. Complete as many entries as needed		ne service providers who
(b) Enter name and EIN or address of person who provide	ed you disclosures on eligible indirect co	mpensation
(b) Farmer of FIN and the control of		
(b) Enter name and EIN or address of person who provide	ed you disclosure on eligible indirect con	npensation
(b) Enter name and EIN or address of person who provide	ed vou disclosures on eliaible indirect co	mpensation
(4) 2		
(b) Enter name and EIN or address of person who provide	ed you disclosures on eligible indirect co	mpensation
	·	·

Schedule C (Form 5500) 2012	Pa	age <b>2-</b> 1	
(b) Enter name and FIN or a	address of person who provided vo	ou disclosures on eligible indirect co	mpensation
(1) -110			
(b) Enter name and EIN or a	address of person who provided yo	ou disclosures on eligible indirect co	mpensation
	<u></u>	<del>-</del>	<u>·</u>
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided yo	u disclosures on eligible indirect cor	mpensation
(h) =			
(D) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided vo	ou disclosures on eligible indirect co	mpensation
(1) -110			
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation

|--|

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)		
AFFILIATE	D SERVICES LLC	`	10510 NE	E 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	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13		1485366	Yes No 🛚	Yes No 🗵		Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
AFFILIATE	D SERVICES LLC			E NORTHUP WAY, SUITE 200 ND, WA 98033		
20-553961	1					
(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		645030	Yes No X	Yes No 🗵		Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
BILL YEAG	GER			48TH AVE W SUITE 350 OOD, WA 98037		
53-144524	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		47485	Yes No X	Yes No X		Yes No X

Page	3	-	2
raye	J	_	_

	•	•		<u> </u>		
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	total compensation
			(a) Enter name and FIN or	address (see instructions)		
KIBBLE &	PRENTICE	<u>'</u>	601 UNIC	N ST., 1000		
			SEATTLE	E, WA 98101		
91-117631	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		42548	Yes No X	Yes No X		Yes No X
			(a) Enter name and EIN or	address (see instructions)		
WASHING	TON DENTISTS INSU	IRANCE AGENC		TH 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		34324	Yes No X	Yes No 🗵		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		21802	Yes No X	Yes No X		Yes No X

Page	3	-	3
Page	J	-	3

	Schedule C	(Form 5500)	2012
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	Schedule C (Form 550	00) 2012		Page <b>3 -</b> 3		
answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ich 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)		
RHD EMPI	LOYEE BENEFITS	·	PO BOX SPOKANI	141389 E VALLEY, WA 99214		
91-195649	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		15365	Yes No 🛚	Yes No 🗵		Yes No X
		(	(a) Enter name and EIN or	address (see instructions)		
MADDOCK	AND ASSOCIATES		ATTN DA FIFE, WA	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?	(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		11728	Yes No 🗵	Yes No 🗵		Yes No X
	•	(	(a) Enter name and EIN or	address (see instructions)		
HUB INTE	RNATIONAL NW LLC		PO BOX BOTHEL	3018 L, WA 98041		
91-203601	5					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22		9868	Yes No X	Yes No X		Yes No X

Page	3 -	4

answered	f "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r 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)		
OLYMPIC	CREST INSURANCE	INC	PO BOX 2 GIG HAR	2538 BOR, WA 98335		
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?	(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		9275	Yes No X	Yes No X		Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
AUTOMOT	IVE BENEFITS CORF	PORATION	PO BOX	13170 EEK, WA 98082		
91-140984		T		40		
(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		9018	Yes No 🛚	Yes No 🗓		Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
SMITHSON	N INSURANCE SERVI		720 VAL	LEY 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		7645	Yes No X	Yes No X		Yes No X

Page	3	-	5
Page	3	-	5

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	r address (see instructions)		
COMPASS	S CONSULTING	·	1201 - 1S	ST AVE S STE 322 E, WA 98134		
91-208934	6					
(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		6435	Yes No X	Yes No X		Yes No X
			(a) Enter name and EIN or	r address (see instructions)		
WEST CO	AST INSURANCE		PO BOX			
(b) Service Code(s)	(c) Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22		6383	Yes No X	Yes No X	(f). If none, enter -0	Yes No X
			(a) Enter name and FIN or	r address (see instructions)		
BELL AND	ERSON	•	600 SW	39TH ST, SUITE 200 N, WA 98057		
91-075627	8					
(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		5783	Yes No X	Yes No X		Yes No X

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Schedule C (Form 5500) 2012
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	Schedule C (Form 550	00) 2012		Page <b>3 -</b> 6		
answered	d "Yes" to line 1a abov	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	total compensation
			(a) Enter name and EIN or	address (see instructions)		
LINDHE IN	NSURANCE			MAIN STREET DALE, WA 98620		
91-153795	54					
(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		5697	Yes No X	Yes No X		Yes No X
			(a) Enter name and EIN or	address (see instructions)		
ALEX SKO	DULIS		PO BOX	15852 E, WA 98115		
30-172535	54			-,		
(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		5650	Yes No 🗵	Yes No 🗵		Yes No X
			(a) Enter name and EIN or	address (see instructions)		
WALLING	FORD FINANCIAL SE	RVICES	236 SE 1 NORMAI	71ST ST NDY PARK, WA 98166		
71-090708	32					
(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		5087	Yes No X	Yes ☐ No X		Yes No X

Page	3	-	7
Page	3	-	7

answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			a) Enter name and EIN or	address (see instructions)		
ETHIX NO	RTHWEST		3309 56T	H ST NW, 107 BOR, WA 98335		
13-428358	9					
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22		5067	Yes No 🛚	Yes No 🗵		Yes No X
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employer organization, or person known to be	(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	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required	(g)  Enter total indirect compensation received by service provider excluding eligible indirect	(h) Did the service provider give you a formula instead of an amount or
	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element (f). If none, enter -0	estimated amount?
			Yes No	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compens	ation, by a service provider, and th	ne service provider is a fiduciary		
or provides contract administrator, consulting, custodial, investment advisory, investment mar questions for (a) each source from whom the service provider received \$1,000 or more in indi provider gave you a formula used to determine the indirect compensation instead of an amou many entries as needed to report the required information for each source.	nagement, broker, or recordkeepin irect 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 (see instructions)	(c) Enter amount of indirect compensation		
	(coo mendency)	compensation		
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe 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 ethe 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	ribe the indirect compensation, including any sed to determine the service provider's eligibility the amount of the indirect compensation.		

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[				
Part II Service Providers Who Fail or Refuse to Provide Information				
4 Provide, to the extent possible, the following information for 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		

Page	6-
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Pa	rt III	Termination Information on Accountants and Enrolled Actuaries (see ins	structions)
а	Name:	(complete as many entries as needed)	<b>b</b> EIN:
C	Positio		B EIIV.
d	Addres		<b>e</b> Telephone:
•	/ ladio		С госраново.
Ex	olanatio	):	
			I
<u>a</u>	Name:		b EIN:
d d	Position Address		e Telephone:
u	Addies	.5.	е тетернопе.
Ex	olanatio	n:	
а	Name:		<b>b</b> EIN:
<u>C</u>	Positio		
d	Addres	SS:	e Telephone:
Exi	olanatio		
а	Name:		<b>b</b> EIN:
С	Positio	n:	
d	Addres	ss:	<b>e</b> Telephone:
Evi	olanatio	<u> </u>	
ᄓ	piariatio	i.	
а	Name:		<b>b</b> EIN:
C	Positio		
d	Addres		e Telephone:
Ex	olanatio	1:	

## 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), 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

2012

This Form is Open to Public Inspection

Part I Annual Report I	dentification Informa	ation						
For calendar plan year 2012 or f	iscal plan year beginning	02/01/	'2012 a	ınd ending	01/31/2013			
A This return/report is for:	a multiemployer plan; a single-employer plan;		8	X a multipl a DFE (s	le-employer plan; or specify)			
B This return/report is:	the first return/report; an amended return/repo	ort;			return/report; plan year return/report (less than 12 months)			
C If the plan is a collectively-bargar	ined plan, check here							
D Check box if filing under:	Form 5558;			automat	ic extension; the DFVC program;			
Part II Basic Plan Infor	special extension (enter mation - enter all reques	description)						
ia Name of plan	That on Felice all reques	ico inomaton		1	b Three-digit			
AFFILIATED ASSOCIA	TIONS OF AMER	ICA HEAL	TH	1'	plan number (PN) > 501			
in the second				1	c Effective date of plan 02/01/2007			
2a Plan sponsor's name and address,	include room or suite number	(employer, if for a	a single-employer p	olan) 2	Employer Identification Number (EiN) 20-1050245			
AFFILIATED ASSOCIA	TIONS OF AMER	ICA		2	c Sponsor's telephone number			
P.O. BOX 3265				2	d Business code (see instructions) 525100			
KIRKLAND 10510 NE NORTHUP W			, *					
KIRKLAND	WA 980:		,					
Caution: A penalty for the late or in Under penalties of perjury and other penalties set as the electronic version of this return/report, and	t forth in the instructions, I declare t	that I have examined	this return/report, inclu		nable cause is established.  ying schedules, statements and attachments, as well			
SIGN HERE		114/13	PATRICK	A CHES	STNUT			
Signature of plan administr	ator Date		Enter name of individual signing as plan administrator					
SIGN HERE		1/14/13	PATRICK A . CHESTANT					
Signature of employer/plan	sponsor Date	<u> </u>	Enter name of	individual sig	gning as employer or plan sponsor			
SIGN								
HERE Signature of DFE.	Date		Enter name of	individual sig	gning as DFE			
Preparer's name (including firm nam	ie, if applicable) and addre	ss; include roor	n or suite numbe	r. (optional)	Preparer's telephone number (optional)			
D. EDSON CLARK CLARK, RAYMOND & (	COMPANY, PLLC				(425) 861-8500			
P.O. BOX 3188	,							
REDMOND	WA 98073	3-3188						
For Paperwork Reduction Act Notice	ce and OMB Control Num	nbers, see the i	nstructions for l	Form 5500.	Form 5500 (2012) v. 120126			

Form 5500 (2012) Page **2** 

3a	Plan administrator's name and address X Same as Plan Sponsor Name X Sar	inistrator's name and address 🗵 Same as Plan Sponsor Name 🗵 Same as Plan Sponsor Address 🛭 3b Administrator's EIN				
		3c Administrator				
4	If the name and/or EIN of the plan sponsor has changed since the last	return/report filed for this pla	an, enter the nam	ne, 4t	O EIN	
_	EIN and the plan number from the last return/report:			4		
а	Sponsor's name	4	C PN			
5	Total number of participants at the beginning of the plan year			5	6,787	
6	Number of participants as of the end of the plan year (welfare plans cor	mplete only lines 6a, 6b, 6c,	and <b>6d</b> ).			
a	Active participants			6a	3,519	
b	Retired or separated participants receiving benefits			6b 6c	26	
d G	Other retired or separated participants entitled to future benefits			6d	3,545	
e	Deceased participants whose beneficiaries are receiving or are entitled	to receive benefits		6e	3,313	
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 (only defined contribu	tion plans			
	complete this item)	6g				
n	h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested 6h					
7	Enter the total number of employers obligated to contribute to the plan					
	complete this item)			7		
8a	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions					
b	If the plan provides welfare benefits, enter the applicable welfare featur	e codes from the List of Pla	n Characteristics	Codes in	the instructions:	
4A	4B 4D 4E					
_		lo.				
ча	Plan funding arrangement (check all that apply)  (1) X Insurance	9b Plan benefit arrangement (check all that apply)				
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) X Insurance (2) Code section	on 412(e)(3) insur	ance con	tracts	
	(3) Trust	(3) Trust	311 + 12(c)(c) in car	41100 0011	indoto	
	(4) General assets of the sponsor	I ' H	sets of the spons	or		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)					
а	Pension Schedules b General Schedules					
	(1) R (Retirement Plan Information)	(1) 📗 н	(Financial Info	rmation)		
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	/ <b>(2)</b>	(Financial Info	rmation -	Small Plan)	
	Purchase Plan Actuarial Information) - signed by the plan  (3)   4 A (Insurance Information)					
	actuary	(4) X C	(Service Provi			
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) D	(DFE/Participa			
	Information) - signed by the plan actuary	(6)   G	(Financial Trar	isaction S	ocnedules)	