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 the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2013

Pensio	on Benefit Guaranty Corporation				Inis	Inspection	ublic
Part I	Annual Report Identif	fication Information				•	
For cale	ndar plan year 2013 or fiscal pla			and ending 12/31	/2013		
A This	return/report is for:	a multiemployer plan;	a multiple	e-employer plan; or			
		x a single-employer plan;	a DFE (s	pecify)			
		_	_				
B This	return/report is:	the first return/report;	the final	return/report;			
		an amended return/report;	a short p	lan year return/report (less	than 12 m	onths).	
C If the	plan is a collectively-bargained	plan, check here				> [
D Chec	D Check box if filing under: Form 5558; automatic extension;				☐ th	e DFVC program;	
	special extension (enter description)					, -	
Part	II Basic Plan Informa	ition—enter all requested informa	ation				
	ne of plan	ontor an requested misma			1b	Three-digit plan	504
COBAL	Γ MORTGAGE, INC. HEALTH &	WELFARE PLAN				number (PN) ▶	501
					1c	Effective date of pl	an
22 Dian	ananaar'a nama and addraga:	include room or suite number (emp	alover if for a single	omployer plan)	2h	09/14/2001 Employer Identification	ation
Za Fiai	i sporisor s riarrie ariu address, i	ncide room of suite number (emp	bloyer, ir for a sirigle-	employer plan)	20	Number (EIN)	ation
COBAL	Γ MORTGAGE, INC.					91-2138037	
					2c	Sponsor's telephor	ne
						number 425-605-3100	n
	LATER AVE NE, SUITE 110 ND, WA 98033		ATER AVE NE, SUIT	ΓE 110	2d	Business code (se	
KIKKLAI	ND, WA 30003	KIKKLANI	D, WA 98033			instructions)	
						522292	
Caution	: A penalty for the late or inco	mplete filing of this return/repor	t will be assessed	unless reasonable cause	is establi	shed.	
		nalties set forth in the instructions, I					
stateme	nts and attachments, as well as	the electronic version of this return	n/report, and to the b	est of my knowledge and b	elief, it is ti	rue, correct, and con	nplete.
SIGN HERE	Filed with authorized/valid elec	tronic signature.					
IILIKE	Signature of plan administra	ator	Date Enter name of individual sig			l signing as plan administrator	
SIGN							
TILICE	Signature of employer/plan	sponsor	Date	Enter name of individual	signing as	employer or plan sp	onsor
SIGN HERE							
HEKE	Signature of DFE Date Enter name of individual signing as DFE						
Preparer	's name (including firm name, if	applicable) and address; include r	room or suite numbe		Preparer's optional)	telephone number	
					optional)		

	Form 5500 (2013) Page 2		
3a	Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address	3b Administrat	or's EIN
		3c Administrat number	or's telephone
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name EIN and the plan number from the last return/report:	ne, 4b EIN	
а	Sponsor's name	4c PN	
5	Total number of participants at the beginning of the plan year	5	715
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
а	Active participants	6a	1026
b	Retired or separated participants receiving benefits	6b	
С	Other retired or separated participants entitled to future benefits	6c	
d	Subtotal. Add lines 6a, 6b, and 6c.	6d	1026
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f	Total. Add lines 6d and 6e.	6f	1026
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
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 (only multiemployer plans complete this item	-	
8a	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic	s Codes in the instructi	ons:
	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics 4A 4B 4H 4Q		ns:
9a	Plan funding arrangement (check all that apply) (1) Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) General assets of the sponsor 9b Plan benefit arrangement (check (1)	e(e)(3) insurance contra	cts
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the	e number attached. (Se	ee instructions)
а	Pension Schedules (1) R (Retirement Plan Information) b General Schedules (1) H (Financial	I Information)	
	Purchase Plan Actuarial Information) - signed by the plan (3) A (Insurance actuary)	Information – Small Place Information) Provider Information)	an)

(5)

(6)

SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

(3)

D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2013

This Form is Open to Public Inspection

		pursuant to EF	RISA section 103(a)(2).		•	mapeonon
For calendar plan year 20	13 or fiscal plan	year beginning 01/01/2013	and e	nding 12/3	1/2013	
A Name of plan COBALT MORTGAGE, IN	IC. HEALTH & \	WELFARE PLAN		ee-digit n number (PN)	>	501
C Plan sponsor's name a COBALT MORTGAGE, IN		2a of Form 5500	The state of the s	oyer Identificati 38037	ion Number (I	EIN)
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
UNITEDHEALTHCARE I	NSURANCE CO	OMPANY				
	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or co	ntract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) F	rom	(g) To
36-2739571	79413	716115	515	01/01/2013	3	12/31/2013
2 Insurance fee and com descending order of the		tion. Enter the total fees and total	I commissions paid. List in line 3	the agents, br	okers, and ot	her persons in
(a) Total a	amount of comn		(b) T	otal amount of	fees paid	
		96335				0
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all persons).			
		nd address of the agent, broker, o		sions or fees w	ere paid	
ALLIANT INSURANCE S	ERVICES INC.		LIVE WAY SUITE 1700 FLE, WA 98101			
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount		(d) Purpose		(e) Organization code
	5107	0 N/A				3
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	sions or fees w	ere paid	
PATRICK J CONROY	.,	600 ST	TEWART ST SUITE 602 TLE, WA 98101		·	
(b) Amount of sales ar	nd hase	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpos	se		(e) Organization code
	91228	0 N/A				3

Schedule A (Form 5500)	2013	Page 2 - 1				
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
(4)	and and address of the agent, profit	.,				
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(o) / tinodit	(a) 1 dipose	0000			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid			
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(O) / timodine	(a) 1 diposes	0000			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
	_					
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(o) / unoun	(4)	3345			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
		Fees and other commissions paid	() 0			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(1)	(2)				
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(h) Amount of sales and har-		Fees and other commissions paid	(2) Omanination			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	, ,	, , ,				

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Pa	art II					
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention 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, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) clifer y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

Page 4	4

Pa		t covers the same grou bined for reporting purp	p of employees of the sooses if such contracts a	are experienc	e-rated as a unit. Whe	ere contract	oloyee organizations(s), the s cover individual employees,
8	Benefit and contract type (check	all applicable boxes)					
	a X Health (other than dental of	r vision) k	Dental	С	Vision		d Life insurance
	e Temporary disability (accid	lent and sickness) f	Long-term disabilit	у д	Supplemental unemp	loyment	h Prescription drug
	i Stop loss (large deductible	j	HMO contract	k	PPO contract		I Indemnity contract
	m ☐ Other (specify) ▶						_
9	Experience-rated contracts:						
•	a Premiums: (1) Amount receiv	ed		9a(1)			
	(2) Increase (decrease) in ar			9a(2)			
	(3) Increase (decrease) in ur	•	•				
	(4) Earned ((1) + (2) - (3))					9a(4)	
	b Benefit charges (1) Claims p	oaid		9b(1)			
	(2) Increase (decrease) in cla	aim reserves		9b(2)			
	(3) Incurred claims (add (1) a	and (2))				9b(3)	
	(4) Claims charged					9b(4)	
	c Remainder of premium: (1)	• ,	, in the second of the second	2 (1)(2)			
	(A) Commissions		•	9c(1)(A)			
	(B) Administrative service		•	9c(1)(B)			
	(C) Other specific acquis		•	9c(1)(C) 9c(1)(D)			_
	(D) Other expenses		•	9c(1)(E)			
	(E) Charges for risks or		•	9c(1)(F)			
	(F) Charges for risks or (G) Other retention char						
	(H) Total retention	_	-			9c(1)(H)	
	(2) Dividends or retroactive		_				
	d Status of policyholder reserv		— •		·	9c(2) 9d(1)	
	(2) Claim reserves	, , ,	•			9d(2)	
	(3) Other reserves					9d(2)	
	Dividends or retroactive rate					9e	
10	Nonexperience-rated contracts:	Telundo dae. (Bo not	morade amount entered	1 III IIII 0 00(2).	.,,	<u> </u>	
. •	Total premiums or subscript	ion charges paid to car	rier			10a	532152
	b If the carrier, service, or other retention of the contract or p	er organization incurred	any specific costs in co	onnection with	h the acquisition or	10b	002102
	Specify nature of costs			- , -			I

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

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

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2013

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection
For calendar plan year 20	13 or fiscal plar	n year beginning 01/01/2013	and er	nding 12/31/2	013
A Name of plan COBALT MORTGAGE, IN	C. HEALTH &	WELFARE PLAN		e-digit number (PN)	501
C Plan sponsor's name a COBALT MORTGAGE, IN		e 2a of Form 5500	D Emplo 91-213	oyer Identification 38037	Number (EIN)
			Coverage, Fees, and Com a unit in Parts II and III can be rep		
1 Coverage Information:		<u> </u>		<u> </u>	
(a) Name of insurance ca	rrier				
UNUM LIFE INSURANCE	COMPANY C	DF AMERICA			
# N FINI	(c) NAIC	(d) Contract or	(e) Approximate number of	F	Policy or contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	m (g) To
01-0278678	62235	581354	480	01/01/2013	01/01/2014
2 Insurance fee and communication descending order of the		ation. Enter the total fees and tot	al commissions paid. List in line 3	the agents, broke	ers, and other persons in
(a) Total a	amount of comr		(b) To	otal amount of fee	es paid
		24618			0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all persons).		
	(a) Name a	nd address of the agent, broker,	or other person to whom commiss	sions or fees were	e paid
WILLIAM M CONROY III		600 S	RDINATED BENEFIT PLANS TEWART ST SUITE 602 TLE, WA 98101		
(b) Amount of sales ar	nd hase	Fee	s and other commissions paid		
commissions pai		(c) Amount	(d) Purpos	е	(e) Organization code
	1112	0			
	(a) Name a	and address of the agent, broker.	or other person to whom commiss	sions or fees were	e paid
PATRICK J CONROY 600 STEWART ST SUITE 602 SEATTLE, WA 98101					
(b) Amount of sales ar	nd base	Fee	es and other commissions paid		
commissions pai		(c) Amount	(d) Purpos	е	(e) Organization code
	23506	0			

Schedule A (Form 5500)	2013	Page 2 - 1				
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
(4)	and and address of the agent, profit	.,				
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(o) / tinodit	(a) 1 dipose	0000			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid			
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(O) / timodine	(a) 1 diposes	0000			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
	_					
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(o) / unoun	(4)	3345			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
		Fees and other commissions paid	() 0			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(1)	(2)				
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(h) Amount of sales and har-		Fees and other commissions paid	(2) Omanination			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
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Part II						
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention 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, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) direct (
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

		Schedule A (Form 5500) 2013		Pa	ge 4		
Part	: III	Welfare Benefit Contract Information If more than one contract covers the same guinformation may be combined for reporting put the entire group of such individual contracts.	roup of employees of the surposes if such contracts	are experienc	e-rated as a unit. Whe	ere contrac	
3 B	enefit	and contract type (check all applicable boxes)					
а	ı 🔲 I	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
е	· 🗍 ·	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemp	loyment	h Prescription drug
i	$\bar{\sqcap}$:	Stop loss (large deductible)	j HMO contract	k	PPO contract		Indemnity contract
n	n X	Other (specify) LIFESTYLE ACCIDENTAL [DEATH AND DISMEMBER	RMENT, LIFE	STYLE LIFE INSURAI	NCE	_
) E:	kperie	ence-rated contracts:					
а	Pre	emiums: (1) Amount received		9a(1)			
	(2)) Increase (decrease) in amount due but unpaid	d	9a(2)			
	(3)) Increase (decrease) in unearned premium res	serve	9a(3)			
	(4)) Earned ((1) + (2) - (3))				9a(4)	
I) Be	enefit 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)	
(R	emainder of premium: (1) Retention charges (o	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)			

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

e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(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, line 2 above, report amount.....

(2) Claim reserves

(3) Other reserves.....

9c(1)(H)

9c(2)

9d(1)

9d(2)

9d(3)

9e

10a

10b

156707

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

10 Nonexperience-rated contracts:

Specify nature of costs

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2013

This Form is Open to Public

, , , , , , , , , , , , , , , , , , , ,		•	ERISA section 103(a)(2).	ormation		Inspection		
For calendar plan year 20	For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013							
A Name of plan COBALT MORTGAGE, IN	NC. HEALTH & V	WELFARE PLAN	В	Three-digit plan number (PN) •	501		
C Plan sponsor's name a COBALT MORTGAGE, IN		e 2a of Form 5500		mployer Identifica 1-2138037	ation Number	(EIN)		
		ing Insurance Contract (Individual contracts grouped as						
1 Coverage Information:	te Scriedule A.	muividuai contracts grouped as	a unit in Faits II and III can be	e reported on a sir	igle Scriedule	: A.		
(a) Name of insurance ca								
UNUM LIFE INSURANCE	E COMPANY O	F AMERICA	(a) Annuarinanta mumban	-4	Dollayere	antract voor		
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number persons covered at end of	of	From	ontract year (g) To		
	0000		policy or contract year			(9)		
01-0278678	62235	579576	1026	01/01/201	3	01/01/2014		
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	al commissions paid. List in li	ne 3 the agents, b	orokers, and o	other persons in		
(a) Total	amount of comm	<u> </u>	(b) Total amount o	of fees paid			
		11964				0		
3 Persons receiving com		ees. (Complete as many entries		•				
WILLIAM M CONROY III	(a) Name a	nd address of the agent, broker,	or other person to whom com RDINATED BENEFIT PLANS		were paid			
WILLIAM M CONROT III		600 S	TLE, WA 98101					
(b) Amount of sales a	nd base		es and other commissions paid	d		_		
commissions pa	iid 1143	(c) Amount	(d) Purpose			(e) Organization code		
	1143	O						
	(a) Name a	nd address of the agent, broker,		missions or fees	were paid			
PATRICK J CONROY 600 STEWART ST SUITE 602 SEATTLE, WA 98101								
(b) Amount of sales a	nd base	Fee	es and other commissions paid	d				
commissions pa	id	(c) Amount	(d) Pu	rpose		(e) Organization code		
	10822	0						

Schedule A (Form 5500)	2013	Page 2 - 1				
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
(4)	and and address of the agent, profit	.,				
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(o) / tinodit	(a) 1 dipose	0000			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid			
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(O) / timodine	(a) 1 diposes	0000			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
	_					
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(o) / unoun	(4)	3345			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
		Fees and other commissions paid	() 0			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(1)	(2)				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(h) Amount of sales and har-		Fees and other commissions paid	(2) Omanination			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	, ,	, , ,				

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Part II						
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C _.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention 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, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) clifer y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

Page 4	
e employer(s) or members of the same emexperience-rated as a unit. Where contracted as a unit for purposes of this report.	
c ☐ Vision g ☐ Supplemental unemployment k ☐ PPO contract	d X Life insurance h ☐ Prescription drug l ☐ Indemnity contract
20/4)	_

		If more than one contract covers the same grainformation may be combined for reporting protection the entire group of such individual contracts of the entire group of the entire group of such individual contracts of the entire group of the entire gr	urposes if such contracts a	are experienc	ce-rated as a unit. Who	ere contrac		
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	c	Vision		d X Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unemp	oloyment	h Prescription drug	
	i [Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract	t
	m	Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT					
9	Expe	erience-rated contracts:						
	•	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	-	•				
		(3) Increase (decrease) in unearned premium res	F					
		(4) Earned ((1) + (2) - (3))				9a(4)		
		Benefit charges (1) Claims paid	The state of the s					
		(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		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	<u> </u>	9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention	_	_		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1	•			9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2)	.)	9e		
10		nexperience-rated contracts:						
		Total premiums or subscription charges paid to o				10a		271078
		If the carrier, service, or other organization incurrent retention of the contract or policy, other than report that the contract or policy, other than report the contract or policy, other than report to the contract or policy.				10b		0
	Sp	ecify nature of costs						

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

Schedule A (Form 5500) 2013

Welfare Benefit Contract Information

Part III

¹² If the answer to line 11 is "Yes," specify the information not provided. **\rightarrow**

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Report Identification Information

Part I

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

2013

This Form is Open to Public Inspection

v. 130118

<u>For calendar plan year 2013 or fiscal pla</u>	an year beginning 01/01/2013		and_ending12/3	11/2013
A This return/report is for:	a multiemployer plan;	a multiple	-employer plan; or	
	x a single-employer plan;	a DFE (sp	ecify)	
				
B This return/report is:	the first return/report;	the final re	eturn/report;	
	an amended return/report;	a short pla	an year return/report (les	s than 12 months).
C If the plan is a collectively-bargained	plan, check here			
D Check box if filling under:	Form 5558;		extension;	the DFVC program;
	special extension (enter desc	*****		
Part II Basic Plan Informa	ationenter all requested informa	- · · · · · · · · · · · · · · · · · · ·		
1a Name of plan	omer an requested informa			1b Three-digit plan
COBALT MORTGAGE, INC. HEALTH &	& WELFARE PLAN			number (PN) → 501
				1c Effective date of plan 09/14/2001
2a Plan sponsor's name and address;	include room or suite number (emp	loyer, if for a single-	employer plan)	2b Employer Identification
COBALT MORTGAGE, INC.				Number (EIN) 91-2138037
				2c Sponsor's telephone number
				425-605-3100
11241 SLATER AVE NE, SUITE 110 KIRKLAND, WA 98033		ATER AVE NE, SUIT D. WA 98033	E 110	2d Business code (see
·		.,		instructions) 522292
				SAZZOZ
				Communication of the Communica
Caution A populty for the late or inge	amplete filing of this return/rener	t will be accessed t	unione roseanable cour	e is astablished
Caution: A penalty for the late or inco Under penalties of perjury and other per				
statements and attachments, as well as	the electronic version of this return	report, and to the be	est of my knowledge and	belief, it is true, correct, and complete.
		, ,	1.7	
SIGN C		624 2014	Keith"	Tibbles
HERE Signature of plan administr	ator	Date	Enter name of individua	al signing as plan administrator
1810(1910(1910(1910(1910)))		1 1		
SIGN C		6/24/3014	Keith	Tibbles
Signature of employer/plan	sponsor	Date	Enter name of individua	al signing as employer or plan sponsor
A CONTROL OF THE CONT				
SIGN HERE				
Signature of DFE		Date	Enter name of individua	al signing as DFE
Preparer's name (including firm name, i	f applicable) and address; include r	oom or suite numbei	r. (optional)	Preparer's telephone number (optional)
				(opaoner)
For Paperwork Reduction Act Notice	and OMB Control Numbers. see	the instructions for	r Form 5500.	Form 5500 (2013)

	Form 5500 (2013) Page 2		
3a	Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address	3b Ad	ministrator's EIN
			ministrator's telephone mber
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	4b EII	N
а	Sponsor's name	4c PN	1
5	Total number of participants at the beginning of the plan year	5	715
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
			4000
а	Active participants	. 6a	1026
b	Retired or separated participants receiving benefits	. 6b	
С	Other retired or separated participants entitled to future benefits.	. 6c	
d	Subtotal. Add lines 6a, 6b, and 6c.	. 6d	1026
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	. 6e	
f	Total. Add lines 6d and 6e.	. 6f	1026
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	. 6g	
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 (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 Cod	les in the	instructions:
b	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Code 4A 4B 4H 4Q	es in the i	nstructions:
9a	Plan funding arrangement (check all that apply) (1) Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust 9b Plan benefit arrangement (check all that apply) (1) Insurance (2) Code section 412(e)(3) (3) Trust 7 Trust		

	(1)		insurance	1	(1)	\wedge	insurance
	(2)		Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts
	(3)		Trust		(3)		Trust
	(4)	\times	General assets of the sponsor		(4)		General assets of the sponsor
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)						
a Pension Schedules b General Schedules						nedules	
	(1)		R (Retirement Plan Information)		(1)		H (Financial Information)
	(2)		MB (Multiemployer Defined Benefit Plan and Certain Money		(2)		I (Financial Information – Small Plan)
			Purchase Plan Actuarial Information) - signed by the plan		(3)	\times	3 A (Insurance Information)
			actuary		(4)		C (Service Provider Information)
	(3)		SB (Single-Employer Defined Benefit Plan Actuarial		(5)		D (DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)		G (Financial Transaction Schedules)