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

2013

This Form is Open to Public Inspection

Pensio	on Benefit Guaranty Corporation				Inspection
Part I	Annual Report Identi				
For cale	ndar plan year 2013 or fiscal pla			and ending 03/31/	2014
A This	return/report is for:	a multiemployer plan;	a multip	le-employer plan; or	
		a single-employer plan;	a DFE (specify)	
B This	return/report is:	the first return/report;	the final	return/report;	
		an amended return/report;	a short p	olan year return/report (less t	han 12 months).
C If the	plan is a collectively-bargained				
D Chec	D Check box if filing under: Form 5558; automatic extension;				the DFVC program;
	-	special extension (enter des	cription)		
Part	II Basic Plan Informa	ation—enter all requested informa	ation		
	ne of plan				1b Three-digit plan
ZETROI	ZETRON, INC. WELFARE BENEFIT PLAN				number (PN) ▶ 301 1c Effective date of plan
					04/01/1991
2a Plar	·	include room or suite number (emp	ployer, if for a single	-employer plan)	2b Employer Identification Number (EIN) 91-1121292
	,,				2c Sponsor's telephone number
РО ВОХ			4TH COURT NE		425-820-6363 2d Business code (see
REDMO	ND, WA 98073	REDMON	ND, WA 98052		instructions) 334500
Caution	: A penalty for the late or inco	omplete filing of this return/repor	rt will be assessed	unless reasonable cause i	s established.
					including accompanying schedules, elief, it is true, correct, and complete.
SIGN HERE	Filed with authorized/valid elec	ctronic signature.	10/23/2014	BRENT DIPPIE	
	Signature of plan administra	ator	Date	Enter name of individual s	signing as plan administrator
SIGN HERE					
TILIXL	Signature of employer/plan	sponsor	Date	Enter name of individual s	signing as employer or plan sponsor
SIGN HERE					
	Signature of DFE		Date	Enter name of individual s	signing as DFE
Preparer	's name (including firm name, if	f applicable) and address; include r	oom or suite numbe		reparer's telephone number optional)

	Form 5500 (2013)	Page 2		
3a	Plan administrator's name and address XSame as Plan Sponsor Name	Same as Plan Sponsor Address	3b Administ	trator's EIN
			3c Administ number	rator's telephone
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		5	214
6	Number of participants as of the end of the plan year (welfare plans complete	e only lines 6a , 6b , 6c , and 6d).		
а	Active participants		. 6a	224
b	Retired or separated participants receiving benefits		6b	(
С	Other retired or separated participants entitled to future benefits		. 6c	0
d	Subtotal. Add lines 6a , 6b , and 6c		6d	224
е	Deceased participants whose beneficiaries are receiving or are entitled to re-	ceive 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	
	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits.	des from the List of Plan Characteristics Code	s in the instruc	
	Plan funding arrangement (check all that apply) (1)	9b Plan benefit arrangement (check all the (1) X Insurance (2) Code section 412(e)(3) Trust (4) X General assets of the specific production of the specific product of the specific produc	insurance con	
10 a	Check all applicable boxes in 10a and 10b to indicate which schedules are a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money	b General Schedules (1) H (Financial Inform (2) I (Financial Inform	mation) nation – Small	
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3) A (Insurance Infor C (Service Provide	,)

(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)

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

For calendar plan year 201	13 or fiscal plan	year beginning 04/01/2013	ar	nd ending	03/31/2014		
A Name of plan			В	B Three-digit			
ZETRON, INC. WELFARE	BENEFIT PLA	.N		plan number	(PN) •	501	
C Plan sponsor's name a	s shown on line	2a of Form 5500	D E	mployer Ident	ification Number (EIN)	
ZETRON, INC.			9.	1-1121292			
- Informati	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract						
		Ing Insurance Contract (Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
PREMERA BLUE CROSS	3						
	(a) NAIC	(d) Contract or	(e) Approximate number	of	Policy or co	ntract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	of	(f) From	(g) To	
91-0499247	47570	4000283	210	04/01/	2013	03/31/2014	
2 Insurance fee and coming descending order of the		tion. Enter the total fees and total	al commissions paid. List in li	ne 3 the agen	ts, brokers, and ot	her persons in	
	amount of comn	nissions paid		b) Total amou	nt of fees paid		
(a) Folding	anount of comm	46438	\	2) Fotal allied	nt or rood paid	6918	
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all persor	าร).			
	(a) Name a	nd address of the agent, broker,		missions or fe	es were paid		
KIBBLE AND PRENTICE	HOLDING COI	MPANY 601 U SEAT	NION STREET, SUITE 1000 TLE, WA 98101				
		52 7	,				
(b) Amount of sales ar	nd base	Fee	s and other commissions paid	d			
commissions pai		(c) Amount	(d) Pu	•		(e) Organization code	
	46438	6918 PF	REFERRED PRODUCER PRO	OGRAM		3	
	(a) Nome o	nd address of the agent, broker,	or other person to whom com	missisms or fo	oo wara naid		
	(a) Name a	nd address of the agent, broker,	or other person to whom com	imissions of te	es were paid		
Fees and other commissions paid							
(b) Amount of sales ar commissions pai		(c) Amount	and other commissions paid (d) Purpose			(e) Organization code	
CO.THITHOGICATO PUL		(-)	(3) 1 0	r		(., g	
For Donomically Dodinatio	n Act Nation o	nd OMP Control Numbers, see	the instructions for Form F	:500	Sahaa	lula A /Farm FEOO) 2012	

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, stone	.,			
		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)	()			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(h) Amount of calca 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

	If more than one contract information may be come the entire group of such	ontract Information ct covers the same group bined for reporting purpo individual contracts with	of employees of the sapses if such contracts a	ire experienc	e-rated as a unit. Whe	ere contract		
8	Benefit and contract type (check	all applicable boxes)						
	a X Health (other than dental of	or vision) b	Dental	CX	Vision		d Life insurance	
	e Temporary disability (acci	dent and sickness) f	Long-term disability	, g	Supplemental unemp	oloyment	h Prescription drug	g
	i Stop loss (large deductible	j	HMO contract	k	PPO contract		I Indemnity contra	ict
	m ☐ Other (specify) ▶	•	—					
9	Experience-rated contracts:							
	a Premiums: (1) Amount receiv	/ed		9a(1)				
	(2) Increase (decrease) in a	mount due but unpaid		9a(2)				
	(3) Increase (decrease) in u	nearned premium reserv	e	9a(3)				
	(4) Earned ((1) + (2) - (3))					9a(4)		
	b Benefit charges (1) Claims	paid		9b(1)				
	(2) Increase (decrease) in cl	laim reserves		9b(2)				
	(3) Incurred claims (add (1)	and (2))				9b(3)		
	(4) Claims charged					9b(4)		
	c Remainder of premium: (1)							
	(A) Commissions			9c(1)(A)				
	(B) Administrative service	ce or other fees		9c(1)(B)			_	
		sition costs		9c(1)(C)			_	
	` ,			9c(1)(D)			4	
	` '		F	9c(1)(E)			4	
	` '	other contingencies		9c(1)(F)			4	
		rges	L	9c(1)(G)		0-(4)(11)		
	` '		_			9c(1)(H)		
	(2) Dividends or retroactive				·	9c(2)		
	d Status of policyholder reser	• , ,	•			9d(1)		
	(2) Claim reserves					9d(2)		
	(3) Other reserves					9d(3)		
4.0	e Dividends or retroactive rate	•	clude amount entered	in line 9c(2) .)	9e		
10	Nonexperience-rated contracts				ĺ			
	a Total premiums or subscrip	- ·				10a		1547933
	b If the carrier, service, or oth retention of the contract or p	•	, ,		•	10b		
	Specify 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	

¹² 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

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

Pension Benefit Guaranty Corporation Insurance companies are required to provide the inform pursuant to ERISA section 103(a)(2).					ion	11113101	Inspection	
For calendar plan year 20	13 or fiscal pla	an year beginning 04/01/201	3	and en	ding 03	3/31/2014		
A Name of plan ZETRON, INC. WELFARE	BENEFIT PL	AN		B Three plan	e-digit number (Pl	N) •	501	
0.5				D			·	
C Plan sponsor's name a ZETRON, INC.		91-112	-	cation Number	(EIN)			
		ning Insurance Contract. Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance ca								
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or c	ontract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
91-0621480	47341	702	4	457 04/01/2013)13	03/31/2014	
2 Insurance fee and com- descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and c	ther persons in	
		nmissions paid		(b) To	tal amount	of fees paid		
		6543					0	
3 Persons receiving com	missions and	fees. (Complete as many entri	es as needed to report all	persons).				
		and address of the agent, broke	•		ions or fees	were paid		
KIBBLE AND PRENTICE	HOLDING CO		I UNION STREET, SUITE ATTLE, WA 98101	≣ 1000				
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
	6543						3	
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees	were paid		
	(4)		,					
(b) Amount of sales and base Fees and other commissions paid								
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code	

Schedule A (Form 5500)	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, stone	.,			
		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)	()			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(h) Amount of calca 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		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

	art II	If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	oup of employees of the surposes if such contracts with each carrier may be t	are experienc	ce-rated as a unit. Wher	e contracts	
8	Ben	efit and contract type (check all applicable boxes)		_	_		_
	а	Health (other than dental or vision)	b X Dental	С	Vision	(Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemplo	yment I	Prescription drug
	i Ē	Stop loss (large deductible)	j HMO contract	k [PPO contract		Indemnity contract
	m	Other (specify)					
9	Expe	erience-rated contracts:					
	•	Premiums: (1) Amount received		9a(1)		261712	
		(2) Increase (decrease) in amount due but unpaid				0	
		(3) Increase (decrease) in unearned premium res				0	
		(4) Earned ((1) + (2) - (3))				9a(4)	261712
	b	Benefit charges (1) Claims paid			1	202131	
		(2) Increase (decrease) in claim reserves				1000	
		(3) Incurred claims (add (1) and (2))				9b(3)	203131
		(4) Claims charged				9b(4)	203131
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)		6543	
		(B) Administrative service or other fees		9c(1)(B)		37948	
		(C) Other specific acquisition costs		9c(1)(C)		0	
		(D) Other expenses		9c(1)(D)		0	
		(E) Taxes		9c(1)(E)		0	
		(F) Charges for risks or other contingencies		9c(1)(F)		0	
		(G) Other retention charges		9c(1)(G)	1	0	
		(H) Total retention				9c(1)(H)	44491
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	0
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	0
		(2) Claim reserves				9d(2)	13000
		(3) Other reserves				9d(3)	0
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2)	.)	9e	0
10		nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to c			-	10a	
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo	, ,			10b	
	Sp	ecify nature of costs					

Part	١٧	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.

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

•			are required to provide the ERISA section 103(a)(2).	HIIOHHAU	OH		Inspection	
For calendar plan year 20°	For calendar plan year 2013 or fiscal plan year beginning 04/01/2013 and ending 03/31/2014							
A Name of plan ZETRON, INC. WELFARE	BENEFIT PLA	AN		B Three plan r	e-digit number (PN))	501	
C Plan sponsor's name a ZETRON, INC.	s shown on line	e 2a of Form 5500		D Employ 91-112	yer Identificat 1292	tion Number	(EIN)	
		ing Insurance Contract Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca								
SUN LIFE ASSURANCE	COMPANY OF	F CANADA						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate num persons covered at e				contract year	
(D) LIN	code	identification number	policy or contract y		(f) From		(g) To	
38-1082080	80802	90423	224		04/01/2013	3	03/31/2014	
2 Insurance fee and commodescending order of the		ation. Enter the total fees and to	tal commissions paid. List	in line 3 t	he agents, b	rokers, and	other persons in	
(a) Total a	amount of comm	missions paid		(b) Tot	tal amount of	fees paid		
		13887					0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all pe	ersons).				
		nd address of the agent, broker			ons or fees w	vere paid		
KIBBLE AND PRENTICE	HOLDING CO		JNION STREET, SUITE 1 ITLE, WA 98101	000				
(b) Amount of sales ar	d base	Fe	es and other commissions	paid				
commissions pai		(c) Amount	(d) Purpose			(e) Organization code		
13887						3		
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(b) Amount of sales ar	id base	Fe	es and other commissions	paid				
commissions pai		(c) Amount	(d) Purpose	!		(e) Organization code	

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, stone	.,	
		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)	()	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid
(h) Amount of calca 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		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				
	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		
I Welfare Benefit Contract Information If more than one contract covers the same goinformation may be combined for reporting pothe entire group of such individual contracts	roup of employees of the sa surposes if such contracts a	re experienc	ce-rated as a unit. V	Vhere contrac	
efit and contract type (check all applicable boxes)					
Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance
Temporary disability (accident and sickness)	f X Long-term disability	g g	Supplemental une	mployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT		ı		ь .
erience-rated contracts:					
Premiums: (1) Amount received		9a(1)			
(2) Increase (decrease) in amount due but unpai	d	9a(2)			
(3) Increase (decrease) in unearned premium res	serve	9a(3)			
(4) Earned ((1) + (2) - (3))				9a(4)	
Benefit charges (1) Claims paid		9b(1)			
(2) Increase (decrease) in claim reserves		9b(2)			
(3) Incurred claims (add (1) and (2))				9b(3)	
(4) Claims charged				9b(4)	
Remainder of premium: (1) Retention charges (c	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)			

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

141314

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

10 Nonexperience-rated contracts:

8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision)

Experience-rated contracts:

m X Other (specify) ▶ACCIDENTAL DEATH AND DISMEMBERMENT

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

(D) Other expenses.....

(E) Taxes.....

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

(H) Total retention.....

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

(2) Claim reserves

(3) Other reserves. Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

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

Part III

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

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

9c(1)(F)

¹² 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

2013

This Form is Open to Public

		pursuant to	ERISA section 103(a)(2).			inspection
For calendar plan year 20	13 or fiscal plar	year beginning 04/01/2013		and en	ding 03	3/31/2014	
A Name of plan ZETRON, INC. WELFARE	BENEFIT PLA	NN .		B Three plan	e-digit number (P	N) •	501
C Plan sponsor's name a ZETRON, INC.	s shown on line	e 2a of Form 5500		D Employ 91-112	-	cation Number (EIN)
		ing Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
WELLSPRING FAMILY S	SERVICES EAF						
(b) FINI	(c) NAIC	(d) Contract or	(e) Approximate n		-	Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
91-0567261	62419	00	2	03	04/01/20	013	03/31/2014
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comr	missions paid		(b) To	tal amount	of fees paid	
		0					0
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	nd address of the agent, broke	r, or other person to who	m commissi	ions or fees	s were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
	,,	<u> </u>					
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code

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, stone	.,	
		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) / tinodin	(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)	()	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid
(h) Amount of calca 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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		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	Current 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		ŭ		
		(3) guaranteed investment				
	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		Page 4		
Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting p the entire group of such individual contracts	roup of employees of the sam urposes if such contracts are	experience-rated as a	unit. Where contract	
efit and contract type (check all applicable boxes)				
Health (other than dental or vision)	b Dental	c Vision		d Life insurance
Temporary disability (accident and sickness)	f Long-term disability	g Supplement	al unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k PPO contra	ct	I Indemnity contract
Other (specify) EMPLOYEE ASSISTANCE	PROGRAM	_		_
erience-rated contracts:				
Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unpaid	db	9a(2)		
(3) Increase (decrease) in unearned premium res	serve	9a(3)		
(4) Earned ((1) + (2) - (3))	<u></u>		9a(4)	
Benefit charges (1) Claims paid		9b(1)		
(2) Increase (decrease) in claim reserves		9b(2)		
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

Yes

No

8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision)

Experience-rated contracts:

10 Nonexperience-rated contracts:

Specify nature of costs

Provision of Information

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

Part IV

m X Other (specify) ▶EMPLOYEE ASSISTANCE PROGRAM

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

Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions

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

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

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

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

(H) Total retention.....

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

(2) Claim reserves

(3) Other reserves..... Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

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

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

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

Part III

9c(1)(A)

9c(1)(B) 9c(1)(C)

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

9c(1)(F)

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

Pens	lon Benefit Guaranty Corporation				This Form is Open to Public Inspection
Part	Annual Report Iden	tification Information			
For cale	endar plan year 2013 or fiscal p	olan year beginning 04	/01/2013	and ending	03/31/2014
A This	return/report is for:	a multiemployer plan;	a multip	le-employer plan; or	
		X a single-employer plan;	a DFE (specify)	
B This	return/report is:	the first return/report;	The final	return/report;	
		an amended return/report;		olan year return/report (less	than 12 months)
C If the	nlan la a collegilyaly harasina	ed plan, check here			
U Che	ck box if filing under:	Form 5558;		ic extension;	the DFVC program;
		special extension (enter de			
Part	II Basic Plan Inform	nation—enter all requested inform	nation		
1a Nar	me of plan Zetron, Inc.	Welfare Benefit Plan	n		1b Three-digit plan
					number (PN) ▶ 501
		59			1c Effective date of plan
2a Pla					04/01/1991
	tron, Inc.	; include room or suite number (em	iployer, if for a single-	-employer plan)	2b Employer Identification Number (EIN)
26	cion, inc.				91-1121292
					2c Sponsor's telephone
DO.	Day 07004				number
PO	Box 97004				(425) 820-6363
	dmond		WA	98073	2d Business code (see
120	034-134th Court NE				Instructions) 334500
Rec	dmond		T-7.7	00050	55.500
NOC	aliona		WA	98052	
•			ment of the second		To the State of th
		omplete filing of this return/repo			
Under po statemen	enallies of perjury and other pe nts and attachments, as well as	enalties set forth in the instructions, s the electronic version of this retur	I declare that I have n/report, and to the b	examined this return/report, est of my knowledge and be	including accompanying schedules, allef, it is true, correct, and complete.
	200		1 1		
SIGN	Buth	1	10/23/14	Brent Dippie	r
HERE	Signature of plan administr	rator	 ` 		
	orgitature or plan auministr	iatoi	Date	Enter name of individual s	igning as plan administrator
SIGN					
HERE					
	Signature of employer/plan	sponsor	Date	Enter name of individual s	igning as employer or plan sponsor
SIGN					
	Signature of DFE	***************************************	Date	Enter name of individual s	igning as DFE
Preparer	's name (including firm name,	if applicable) and address; include	room or suite number	r. (optional) Pr	reparer's telephone number
				(0	ptional)
				723.00	
				122.00	
r D	muncle Doduction Ant Matter			The state of the s	

	Form 5500 (2013) 130118		Pag	je 2			
3a	Plan administrator's name and address XSame as Plan Sponsor Name	Same	as Plan	Spon	sor Address	3b Adn	ninistrator's EIN
						1	ninistrator's telephone nber
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/repor	t filed for	this p	plan, enter the name,	4b EIN	<u> </u>
a	Sponsor's name					4c PN	
5	Total number of participants at the beginning of the plan year					5	214
6	Number of participants as of the end of the plan year (welfare plans complete	te only	lines 6a,	6b, 6	ic, and 6d).		
а	Active participants					. 6a	224
b	Retired or separated participants receiving benefits					. 6b	0
С	Other retired or separated participants entitled to future benefits					. 6c	0
d	Subtotal. Add lines 6a, 6b, and 6c					. 6d	224
е	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive I	penefits.			. 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)	(only	defined o	ontrib	oution plans	. 6g	
h	Number of participants that terminated employment during the plan year witl less than 100% vested					6h	
7	Enter the total number of employers obligated to contribute to the plan (only	multie	mployer	plans	complete this item)	. 7	
	If the plan provides pension benefits, enter the applicable pension feature of the plan provides welfare benefits, enter the applicable welfare feature could 4 A 4 B 4 D 4 E 4 F 4 H 4 L 4 Q						
	Plan funding arrangement (check all that apply) (1) X Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) X General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are a		(1) (2) (3) (4)	X	Irrangement (check all the Insurance Code section 412(e)(3) Trust General assets of the sindicated, enter the numerous content in the section of the section	insurance	
a	Pension Schedules	b	Genera	l Sch	edules		
	(1) R (Retirement Plan Information)		(1)	П	H (Financial Infor	mation)	

(2)

(3)

(4)

(5)

(6)

I (Financial Information - Small Plan)

C (Service Provider Information)D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

4 A (Insurance Information)

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

(2)

(3)

actuary

⁴Q REPRESENTS EMPLOYEE ASSISTANCE PROGRAM. FSA INLCUDED.

Attachment to 2013 Form 5500 Form M-1 Compliance Information

	Name Zetron, Inc. Welfare Benefit Plan Sponsor's Name Zetron, Inc.	EIN: 91-1121292 PN: 501			
1.	If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year?	Yes No 🗓			
	If "Yes" is checked, complete lines 2 and 3.				
2.	Is the plan currently in compliance with Form M-1 filing requirements?	Yes No			
3.	Enter the Receipt Confirmation Code for the 2013 Form M-1 annual report. If the plan was not required to file the 2013 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)				
	Receipt Confirmation Code				