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	n Benefit Guaranty Corporation					Inspection	
Part I	Annual Report Identif						
For cale	ndar plan year 2013 or fiscal pla	an year beginning 02/01/2013		and ending 01/31/	2014		
A This return/report is for: ☐ a multiemployer plan; ☐ a multiple-employer plan; or							
		a single-employer plan;	a DFE (s	pecify)			
B This	eturn/report is:	the first return/report;	the final	return/report;			
	·	an amended return/report;	a short p	lan year return/report (less t	han 12 m	onths).	
C If the	plan is a collectively-bargained	plan, check here				> [
D Chec	k box if filing under:	Form 5558;	automati	c extension;	th	e DFVC program;	
		special extension (enter desc	. ,				
Part		ation—enter all requested informat	ion		1		ı
	ie of plan TED ASSOCIATIONS OF AME	RICA HEALTH CARE TRUST			1b	Three-digit plan number (PN) ▶	501
7 (1 1 1 1 1 1 7)	TED NOOCONTHONO OF TIME	MONTENETH ONKE TROOT			1c	Effective date of pla	an
0- 5					Ol-	02/01/2007	
	sponsor's name and address; in the sponsor name and address name address name and address name	include room or suite number (empl	oyer, if for a single-	employer plan)	20	Employer Identifica Number (EIN) 20-1050245	ition
					2c	2c Sponsor's telephone number	
P.O. BOX 3265 KIRKLAND, WA 98033 10510 NE NORTHUP WAY, SUITE 200 KIRKLAND, WA 98033			UITE 200	2d	Business code (see instructions) 525100	е	
Caution	A penalty for the late or inco	omplete filing of this return/report	will be assessed	unless reasonable cause	s establi	shed.	
		nalties set forth in the instructions, I on the electronic version of this return/					
SIGN HERE	Filed with authorized/valid elec	tronic signature.					
	Signature of plan administra	ator	Date	Enter name of individual s	signing as	plan administrator	
SIGN HERE							
TILKE	Signature of employer/plan	sponsor	Date	Enter name of individual	signing as	employer or plan sp	onsor
SIGN							
HERE	Signature of DFE		Date	Enter name of individual s	igning as	DFE	
		applicable) and address; include ro		r. (optional)		telephone number	
	RAYMOND & COMPANY, PLL	С			, p	425-861-8500	
P.O. BO REDMO	X 3188 ND, WA 98073-3188						

	Form 5500 (2013)	Pa	ge 2		
3a	Plan administrator's name and address XSame as Plan Sponsor Name	Same as Pla	an Sponsor Address	3b Administrat	or's EIN
				3c Administrate number	or'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:	rn/report filed f	or 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	3545
6	Number of participants as of the end of the plan year (welfare plans comple	ete only lines 6	a, 6b, 6c, and 6d).		
а	Active participants			6a	4043
b	Retired or separated participants receiving benefits			6b	15
С	Other retired or separated participants entitled to future benefits			6с	131
d	Subtotal. Add lines 6a, 6b, and 6c			6d	4189
е	Deceased participants whose beneficiaries are receiving or are entitled to r	eceive benefits	s	6e	
f	Total. Add lines 6d and 6e .			6f	
g	Number of participants with account balances as of the end of the plan yea complete this item)			6g	
h	Number of participants that terminated employment during the plan year wiless than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only				
	If the plan provides pension benefits, enter the applicable pension feature of the plan provides welfare benefits, enter the applicable welfare feature con 4A 4B 4D 4E				
9a 10	Plan funding arrangement (check all that apply) (1)	(1) (2) (3) (4)	lenefit arrangement (check all Insurance Code section 412(e)(: Trust General assets of the	3) insurance contract	
	Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money		ral Schedules H (Financial Info	·	·
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3) (4)	X 4 (Insurance Int	formation) vider Information)	,
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)		ating Plan Informati	on)

(6)

G (Financial Transaction Schedules)

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

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

		pursuant to	ERISA section 103(a)(2).			inspection	
For calendar plan year 20°	13 or fiscal pla	an year beginning 02/01/2013		and ending 0	1/31/2014		
A Name of plan AFFILIATED ASSOCIATION	ONS OF AME	RICA HEALTH CARE TRUST	В	Three-digit plan number (F	PN) •	501	
C Plan sponsor's name a AFFILIATED ASSOCIATION				Employer Identifi 20-1050245	cation Number (EIN)	
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
UNIMERICA INSURANC	E COMPANY		1				
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate numbe persons covered at end	Lof	Policy or co	•	
(b) LIN	code	identification number	policy or contract year) From	(g) To	
36-2739571	91529	666		05/01/2	013	04/30/2014	
2 Insurance fee and come descending order of the		nation. Enter the total fees and to	otal commissions paid. List in	line 3 the agents	, brokers, and ot	her persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
	0						
3 Persons receiving com		fees. (Complete as many entries					
	(a) Name	and address of the agent, broke	r, or other person to whom cor	mmissions or fee	s were paid		
(b) Amount of sales ar	nd base	Fe	es and other commissions pa	iid			
commissions pai		(c) Amount	(d) P	urpose		(e) Organization code	
	(a) Name	and address of the agent, broke	r. or other person to whom cor	mmissions or fee	s were paid		
	(a)	ana aaa. oo o a a o ago ii, aro o	, o. ea. poses e		pa		
(b) Amount of sales ar	nd base	Fe	es and other commissions pa	id			
commissions pai		(c) Amount	(d) P	urpose		(e) Organization code	

Schedule A (Form 5500)	2013	Page 2 - 1					
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were 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)	(2)					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere 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				
	, ,	, , ,					

_		
മര	Δ	
ıay		•

Р	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contra	cts with each carrier ma	ay be treated as a	a unit for purposes of
		this report.			· ·	
		rent value of plan's interest under this contract in the general account at year				
_		rent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	L	Describera a cid to contra			Ch.	
	b	Premiums paid to carrier.			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.		•	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	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma		<u> </u>		
	а	Type of contract: (1) deposit administration (2) immedia				
		(3) guaranteed investment (4) other		ŭ		
		(3) U guaranteed investment				
	b	Balance at the end of the previous year			7b	
	C	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	<u> </u>
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				
					1	

	Schedule A (Form 5500) 2013		Pag	ge 4		
Part III	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pr the entire group of such individual contracts or	oup of employees of the saurposes if such contracts an	re experienc	e-rated as a unit. Where co	ontracts o	
8 Benefi	t and contract type (check all applicable boxes)					
а	Health (other than dental or vision)	b Dental	С	Vision	d	Life insurance
е	Temporary disability (accident and sickness)	f Long-term disability	g∏	Supplemental unemploym	nent h	Prescription drug
i ∏	Stop loss (large deductible)	j HMO contract	k	PPO contract	- 1	Indemnity contract
m 🗍	Other (specify)	_	_			_
9 Experie	ence-rated contracts:	_				
a Pro	emiums: (1) Amount received		9a(1)			
(2) Increase (decrease) in amount due but unpaid	J	9a(2)			
(3) Increase (decrease) in unearned premium res	erve	9a(3)			
(4) Earned ((1) + (2) - (3))			9	a(4)	
b B	enefit charges (1) Claims paid		9b(1)			
(2) Increase (decrease) in claim reserves		9b(2)			
(3) Incurred claims (add (1) and (2))	-		9	b(3)	
(4) Claims charged			9	b(4)	
CR	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		9c(1)(G)			
	(H) Total retention			90	(1)(H)	
(2	2) Dividends or retroactive rate refunds. (These	_			c(2)	
	tatus of policyholder reserves at end of year: (1	ш .	ш	·	d(1)	

9d(2)

9d(3)

9e

10a

10b

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

(2) Claim reserves

(3) Other reserves.....

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.....

10 Nonexperience-rated contracts:

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

2013

		pursuant to	ERISA section 103(a)(2)				inspection
For calendar plan year 20	13 or fiscal plar	n year beginning 02/01/2013		and end	ding 01	/31/2014	
A Name of plan AFFILIATED ASSOCIATION	ONS OF AMER	RICA HEALTH CARE TRUST		B Three plan	e-digit number (P	N) •	501
C Plan sponsor's name a AFFILIATED ASSOCIATION				D Employ 20-105		cation Number (EIN)
		ing Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
UNITED HEALTHCARE I	INSURANCE C	COMPANY					
(In) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
36-2739571	79413	301705			05/01/20	013	04/30/2014
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3 t	the agents,	brokers, and of	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		0					0
3 Persons receiving com	missions and fo	ees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker	, or other person to who	m commissi	ons or fees	s were paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose)		(e) Organization code
	(a) Name a	and address of the agent, broker	, or other person to who	m commissi	ons or fees	s were paid	
		<u>, , , , , , , , , , , , , , , , , , , </u>	, ,				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid		_	
commissions pai		(c) Amount		(d) Purpose)		(e) Organization code

Schedule A (Form 5500)	2013	Page 2 - 1					
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were 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)	(2)					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere 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				
	, ,	, , ,					

_		
മര	Δ	
ıay		•

Р	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contra	cts with each carrier ma	ay be treated as a	a unit for purposes of
		this report.			· ·	
		rent value of plan's interest under this contract in the general account at year				
_		rent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	L	Describera a cid to contra			Ch.	
	b	Premiums paid to carrier.			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.		•	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	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma		<u> </u>		
	а	Type of contract: (1) deposit administration (2) immedia				
		(3) guaranteed investment (4) other		ŭ		
		(3) U guaranteed investment (4) U other 7				
	b	Balance at the end of the previous year			7b	
	C	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	<u> </u>
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				
					1	

	Schedule A (Form 5500) 2013		Pa	ge 4	_	
Part	Welfare Benefit Contract Informat If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the surposes if such contracts	are experienc	e-rated as a unit. Whe	re contract	
8 Be	nefit and contract type (check all applicable boxes)					
а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance
е	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unemp	loyment	h Prescription drug
i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
m		, 🗆		1		- 🗆,
•••	Other (specify)					
9 Ext	erience-rated contracts:					
•	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpaid	d				1
	(3) Increase (decrease) in unearned premium res	serve	9a(3)			
	(4) Earned ((1) + (2) - (3))				9a(4)	
b	Benefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))				9b(3)	
	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (c	n an accrual basis)				
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses		9c(1)(D)			_
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies.		9c(1)(F)			
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention				9c(1)(H)	

9c(2)

9d(1)

9d(2)

9d(3)

9e

10a

10b

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

(2) Claim reserves

(3) Other reserves.....

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).).....

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

10 Nonexperience-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	

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

			ERISA section 103(a)(2).	mation	Inspection		
For calendar plan year 20	13 or fiscal pla	in year beginning 02/01/2013	and	l ending 01/31/2014			
A Name of plan AFFILIATED ASSOCIATION	ONS OF AME	RICA HEALTH CARE TRUST		hree-digit olan number (PN)	501		
C Plan sponsor's name a AFFILIATED ASSOCIATION				nployer Identification Nui 1050245	mber (EIN)		
			Coverage, Fees, and Cos a unit in Parts II and III can be				
1 Coverage Information:		marriada contidoto groupou di		oportod on a omgre con	oddio 7 t.		
(a) Name of insurance ca	rrier						
VISION SERVICE PLAN							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		y or contract year		
(b) EIN	code	identification number	policy or contract year	(f) From	(g) To		
91-6056925	47317	12256001	4081	07/01/2013	06/30/2014		
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. List in line	e 3 the agents, brokers,	and other persons in		
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid						
		0			0		
3 Persons receiving com			s as needed to report all persons				
	(a) Name	and address of the agent, broke	r, or other person to whom comm	nissions or fees were pai	id		
		Fe	ees and other commissions paid				
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purp	(e) Organization code			
	(a) Name	and address of the agent, broke	r, or other person to whom comm	nissions or fees were pai	id		
	(-)		·, · · · · · · · · · · · · · · · · · ·		···		
(b) Amount of sales ar			ees and other commissions paid				
commissions pa	id	(c) Amount	(d) Purp	oose	(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)	(2)	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere 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
	, ,	, , ,	

_		
മര	Δ	
ıay		•

Р	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contra	cts with each carrier ma	ay be treated as a	a unit for purposes of
		this report.			· ·	
		rent value of plan's interest under this contract in the general account at year				
_		rent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	L	Describera a cid to contra			Ch.	
	b	Premiums paid to carrier.			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.		•	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	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma		<u> </u>		
	а	Type of contract: (1) deposit administration (2) immedia				
		(3) guaranteed investment (4) other		ŭ		
		(3) U guaranteed investment (4) U other 7				
	b	Balance at the end of the previous year			7b	
	C	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	<u> </u>
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				
					1	

Page 4		

Pa	rt 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 v	oup o	es if such contracts a	are exper	ienc	e-rated as a unit. Wh	ere contrac		
8	Bene	fit and contract type (check all applicable boxes)								
	а	Health (other than dental or vision)	b	Dental	(CX	Vision		d	Life insurance
	е	Temporary disability (accident and sickness)	f	Long-term disabilit	y (gΠ	Supplemental unem	oloyment	h	Prescription drug
	ιĒ	Stop loss (large deductible)	jΓ	HMO contract		k∏	PPO contract		ıΠ	Indemnity contract
	m	Other (specify)		•					_	
0		wing an article of a subspace.								
9	•	rience-rated contracts:		ſ	00(4)	ı		140020	4	
		Premiums: (1) Amount received		İ	9a(1) 9a(2)	_		149039	-	
		(2) Increase (decrease) in amount due but unpaic(3) Increase (decrease) in unearned premium res		ľ	``				-	
		(4) Earned ((1) + (2) - (3))		<u>.</u>				9a(4)		149039
		Benefit charges (1) Claims paid			9b(1)			123744		
		(2) Increase (decrease) in claim reserves		ľ	9b(2)			6735	┪	
		(3) Incurred claims (add (1) and (2))						9b(3)		130479
		(4) Claims charged						9b(4)		
		Remainder of premium: (1) Retention charges (o								
		(A) Commissions		·	9c(1)(A	١)				
		(B) Administrative service or other fees			9c(1)(E			27673		
		(C) Other specific acquisition costs			9c(1)(C	;)				
		(D) Other expenses			9c(1)(E))				
		(E) Taxes			9c(1)(E					
		(F) Charges for risks or other contingencies			9c(1)(F	-				
		(G) Other retention charges			9c(1)(0	3)				
		(H) Total retention						9c(1)(H)		27673
		(2) Dividends or retroactive rate refunds. (These	amo	unts were 🗌 paid in	cash, or		credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Am	ount held to provide	benefits a	ıfter	retirement	9d(1)		
		(2) Claim reserves						9d(2)		30936
		(3) Other reserves						9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	ot inc	lude amount entered	l in line 9	(2).)	9e		
10	Nor	nexperience-rated contracts:								
	а	Total premiums or subscription charges paid to c	arrier					10a		
		If the carrier, service, or other organization incurr		, ,			•	406		
		retention of the contract or policy, other than repo	rted	in Part I, line 2 above	e, report a	amo	unt	10b		
	Spe	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	

Schedule A (Form 5500) 2013

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

Tension Benefit Guaranty Oc	проганоп	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					Inspection
For calendar plan year 20	13 or fiscal pl	an year beginning 02/01/201	3	and en	iding 01/	31/2014	
A Name of plan AFFILIATED ASSOCIATION	ONS OF AME	RICA HEALTH CARE TRUST			e-digit number (PN	l) >	501
C Plan sponsor's name a AFFILIATED ASSOCIATION				D Emplo 20-105		ation Number	(EIN)
		ning Insurance Contract Individual contracts grouped a					
(a) Name of insurance ca							
/I-> FINI	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or c	ontract year
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	(g) To
91-0621480	47341	115-504-505-506	49	83	02/01/201	13	01/31/2014
2 Insurance fee and complete descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, l	brokers, and o	other persons in
		nmissions paid		(b) To	otal amount o	of fees paid	
		0					0
3 Persons receiving com		fees. (Complete as many entrie					
		and address of the agent, broke			ions or rees	were paid	1
(b) Amount of sales ar commissions pai		(c) Amount	ees and other commission	(d) Purpose			(e) Organization code
commissions par		(o) / whoch		(a) i dipoo	<u> </u>		(b) organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
	(3)		, , , , , , , , , , , , , , , , , , , ,				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(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)	(2)	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere 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
	, ,	, , ,	

_		
മര	Δ	
ıay		•

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contra	cts with each carrier ma	ay be treated as a	a unit for purposes of
		this report.			· ·	
		rent value of plan's interest under this contract in the general account at year				
_		rent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	L	Describera a cid to contra			Ch.	
	b	Premiums paid to carrier.			6b	
	۲ C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.		•	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	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma		<u> </u>		
	а	Type of contract: (1) deposit administration (2) immedia				
		(3) guaranteed investment (4) other		ŭ		
		(3) U guaranteed investment				
	b	Balance at the end of the previous year			7b	
	C	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)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	<u> </u>
		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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				
					1	

Page 4	- .
ployer(s) or members of the s	ame er

		Schedule A (Form 5500) 2013		Pa	age 4		
Pa	rt I	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pr the entire group of such individual contracts of	roup of employees of the urposes if such contracts	are experience	ce-rated as a unit. Whe	ere contracts c	
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b X Dental	С	Vision	d	Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	oloyment h	Prescription drug
	i [Stop loss (large deductible)	j HMO contract	k [PPO contract	I[Indemnity contract
	m	Other (specify)					
	,						
9	Ехр	erience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)		3132690	
		(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)	3132690
	b	Benefit charges (1) Claims paid				2750702	
		(2) Increase (decrease) in claim reserves		9b(2)		26001	
		(3) Incurred claims (add (1) and (2))				9b(3)	2776703
		(4) Claims charged				9b(4)	
	С	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)		241217	
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes					
		(F) Charges for risks or other contingencies					
		(G) Other retention charges					
		(H) Total retention				9c(1)(H)	241217
		(2) Dividends or retroactive rate refunds. (These	e amounts were 🗌 paid ir	n cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	r retirement	9d(1)	
		(2) Claim reserves				9d(2)	145000
		(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	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to o	carrier			10a	
	b	If the carrier, service, or other organization incur					
	retention of the contract or policy, other than reported in Part I, line 2 above, report amount				10b		

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

Specify nature of costs >

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

Service Provider Information

File as an attachment to Form 5500.

OMB No. 1210-0110

2013

This Form is Open to Public Inspection.

Pension Benefit Guaranty Corporation					
For calendar plan year 2013 or fiscal pla	n year beginning 02/01/2013		and ending 01/31/	2014	
A Name of plan		E	3 Three-digit		501
AFFILIATED ASSOCIATIONS OF AME	RICA HEALTH CARE TRUST		plan number (PN)	•	301
C Plan sponsor's name as shown on lin	e 2a of Form 5500	0	Employer Identification	n Number (EIN)
AFFILIATED ASSOCIATIONS OF AME	RICA		20-1050245		
Part I Service Provider Info	rmation (see instructions)				
or more in total compensation (i.e., mplan during the plan year. If a person	dance with the instructions, to report the coney or anything else of monetary value) received only eligible indirect compensanclude that person when completing the received that person when complete the received the received that person when complete the received the recei	in connection wi	th services rendered to t e plan received the requi	the plan or t	he person's position with the
1 Information on Persons Rec	eiving Only Eligible Indirect Co	ompensation	า		
	er you are excluding a person from the re	-		ed only elig	ible
indirect compensation for which the pl	an received the required disclosures (see	instructions for	definitions and condition	ıs)	Yes X No
	the name and EIN or address of each pe sation. Complete as many entries as nee			or the servic	e providers who
(b) Enter nar	me and EIN or address of person who pro	vided you disclo	sures on eligible indirect	t compensa	tion
(b) Enter no	me and EIN or address of person who pro	vidad vau diaak	sours on aligible indirect	aamnanaati	on.
(b) Litter Hai	The and Envior address of person who pro	Widea you discit	osure on engible manect	Compensau	OII
(b) Enter nan	ne and EIN or address of person who pro	vided you disclo	sures on eligible indirect	compensat	ion
(b) Enter nan	ne and EIN or address of person who pro	vided you disclo	sures on eligible indirect	compensat	ion
• •	<u> </u>				

Schedule C (Fo	orm 5500) 2013	Page 2- 1
((b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
	(b) Enter name and EIN or address of person who provided y	you disclosures on eligible indirect compensation
	E) Enter hame and Env of address of person who provided	you disclosures on eligible mailed compensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
	b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
	h) Fatar ages and FIN or address of access who gravided	
	b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation
((b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect compensation

P

Schedule C (Form 5500) 2013

answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation in the person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN or	address (see instructions)		
AFFILIATE	ED SERVICES LLC		10510 NE	NORTHUP WAY, SUITE 200 D, WA 98033		
20-553961	1					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13		1520638	Yes No 🛚	Yes No 🗵		Yes No X
		(a) Enter name and EIN or	address (see instructions)		
AFFILIATE 20-553961	D SERVICES LLC		10510 N KIRKLAN	E NORTHUP WAY, SUITE 200 ND, WA 98033		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22		871842	Yes No X	Yes No X		Yes No X
	•	(a) Enter name and EIN or	address (see instructions)		
KIBBLE &	PRENTICE			ON ST., 1000 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		42754	Yes No X	Yes No X		Yes No X

Page 3 - 2	age	3 -	2
-------------------	-----	-----	---

Schedule C (Form	5500) 2013
------------------	------------

answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation or person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	total compensation
		((a) Enter name and EIN or	address (see instructions)		
BILL YEAC	GER			8TH 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		40677	Yes No X	Yes No 🗵		Yes No X
		((a) Enter name and EIN or	address (see instructions)		
HRNOVAT	TIONS LLC			TH AVE NE, SUITE 300 UE, WA 98004		
91-149510	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		19544	Yes No 🗵	Yes No 🛚		Yes No X
			(a) Enter name and EIN or	address (see instructions)	I .	
WASHING	TON DENTISTS INSU	JRANCE 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?	(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		18352	Yes No 🛚	Yes No 🗵		Yes No X

Page	3 .	- 3

Schedule C (Form	5500) 2013
------------------	------------

answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
-		((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		14093	Yes No X	Yes No X		Yes No X
		((a) Enter name and EIN or	address (see instructions)		
MADDOCK 91-128040	AND ASSOCIATES		ATTN D/ FIFE, W/	AVE MADDOCK 1407 WILLOW A 98424	/ ROAD	
(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		11592	Yes No 🗓	Yes No 🗵		Yes No X
	•	((a) Enter name and EIN or	address (see instructions)		
AUTOMOT	TIVE BENEFITS CORE	PORATION	PO BOX MILL CR	.13170 EEEK, WA 98082		
91-140984	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		8031	Yes No 🗓	Yes No 🗵		Yes No X

Page 3 - 4

Schedule C (Fo	orm 5500)	2013
----------------	-----------	------

answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and EIN or	address (see instructions)		
HUB INTE	RNATIONAL NW LLC		PO BOX :	, ,		
91-203601	5					
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22		7393	Yes No X	Yes No 🗵		Yes No X
		((a) Enter name and EIN or	address (see instructions)		
COMPASS	CONSULTING			ST AVE S STE 322 E, WA 98134		
91-208934						
(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		5998	Yes No 🗵	Yes No 🗵		Yes No X
	-	((a) Enter name and EIN or	address (see instructions)	-	
ALEX SKC	DULIS		PO BOX SEATTL	.15852 E, WA 98115		
30-172535	4					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22		5709	Yes No 🛚	Yes No X		Yes No X

Page	3	-	5	
Page	3	-	5	

answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and FIN or	address (see instructions)		
SMITHSOI	N INSURANCE SERV	`	720 VALL	EY MALL PARKWAY ENATCHEE, WA 98802		
53-758937	1					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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		5699	Yes No 🗵	Yes No 🗓		Yes No X
		(a) Enter name and EIN or	address (see instructions)		
FORTUNE	MANAGEMENT GRO	DUP	PO BOX	648 AND, WA 98333		
91-192711	0					
(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		5004	Yes No 🗵	Yes No 🗵		Yes No X
		(a) Enter name and EIN or	address (see instructions)		<u>'</u>
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
_			Yes No	Yes No		Yes No

Part I Service Provider Information (continued)

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

Part II Service Providers Who Fail or Refuse to Provide Information				
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-
------	----

Pa	rt III	Termination Information on Accountants and Enrolled Actuaries (see insecomplete as many entries as needed)	structions)
а	Name:	(complete as many entires as needed)	b EIN:
C	Positio		D LIN.
d	Addres		e Telephone:
u	Addres	5.	e Telepriorie.
Ev	planation	<u>_</u>	
나사	piariatioi	•	
			L
а	Name:		b EIN:
C	Positio		
d	Addres	S:	e Telephone:
Ex	olanatior		
а	Name:		b EIN:
С	Positio	n:	
d	Addres	s:	e Telephone:
Ex	olanatior		
а	Name:		b EIN:
С	Positio	n:	
d	Addres		e Telephone:
			·
Ex	olanation	:	
а	Name:		b EIN:
C	Positio)·	w =03.
d	Addres		e Telephone:
u	Addres	s.	тетернопе.
	olonotic:	<u>_</u>	
⊏X	planatior		

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

	Public Inspection
Part I Annual Report Identification Information	
For calendar plan year 2013 or fiscal plan year beginning 02/01/2013 and ending	01/31/2014
A This return/report is for: a multiemployer plan;	le-employer plan; or
a single-employer plan; a DFE (s	pecify)
	return/report;
	olan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here	ic extension; the DFVC program;
D Check box if filing under: X Form 5558; automat special extension (enter description)	ic extension, the brive program,
Part II Basic Plan Information - enter all requested information	
	b Three-digit
AFFILIATED ASSOCIATIONS OF AMERICA HEALTH	plan number (PN) 📂 501
	c Effective date of plan
	02/01/2007
28 Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)	b Employer Identification Number (EIN)
	20-1050245
AFFILIATED ASSOCIATIONS OF AMERICA	c Sponsor's telephone number
	d Business code (see instructions)
P.O. BOX 3265	525100
KTRKLAND WA 98033	
KIRKLAND WA 98033 10510 NE NORTHUP WAY, SUITE 200	
10310 ME MONIMOL WAI, BOILD 200	
KIRKLAND WA 98033	
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reason	nable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompan as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.	ying schedules, statements and attachments, as well
The second second	
SIGN PATRICK A CHE	STNUT
HERE Signature of plan administrator Date Enter name of individual signature.	gning as plan administrator
211 dant 11	
SIGN HERE PATRICK A CHE	
Signature of employer/plan sponsor Date Enter name of individual signature	gning as employer or plan sponsor
SIGN	
HERE	gning as DEE
Signature of DFE Date Enter name of individual signature.	
Preparer's name (including firm name, if applicable) and address; include room or suite number. (optional)	Preparer's telephone number
	(optional)
n EDGON OI ARK	(425) 861-8500
D. EDSON CLARK CLARK, RAYMOND & COMPANY, PLLC	
P.O. BOX 3188	
REDMOND WA 98073-3188	
21000 200 2100	
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.	Form 5500 (2013) v. 130118

318402	
07-17-	1

b General Schedules

С

D

(1)

(2)

(3)

(4)

(5)

(6)

(Financial Information)

(Insurance Information)

(Financial Information - Small Plan)

(DFE/Participating Plan Information)

(Financial Transaction Schedules)

(Service Provider Information)

(See instructions)

a Pension Schedules

actuary

(1)

(2)

(3)

R (Retirement Plan Information)

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary