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

2014

This Form is Open to Public Inspection

Part I		entification Information						
For cale	For calendar plan year 2014 or fiscal plan year beginning 01/01/2008 and ending 12/31/2008							
A This	A This return/report is for: a multiemployer plan; a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or						ons); or	
		X a single-employer plan;	a DFE (speci	cify)				
B This	return/report is:	X the first return/report;	the final retur	rn/report;				
	•	an amended return/report;	a short plan	year return/report (less tha	n 12 month	2 months).		
C If the	C If the plan is a collectively-bargained plan, check here							
D Check box if filing under: Form 5558; automatic extension;					_	the DFVC program;		
2 000	special extension (enter description)							
Part	II Basic Plan Infor	mation—enter all requested informa	ation					
1a Nam	ne of plan AIRCRAFT DESIGN BENE	·			1b	Three-digit plan number (PN) ▶	501	
					1c	Effective date of pl 01/01/2008	an	
2a Plar	sponsor's name and addre	ess; include room or suite number (emp	oloyer, if for a single-	-employer plan)	2b	Employer Identifica	ation	
QUEST	AIRCRAFT DESIGN LLC					Number (EIN) 82-0535946		
QUEST	AIRCRAFT COMPANY LLC				2c	Plan Sponsor's tele	enhone	
						number	•	
	IRBINE DRIVE DINT, ID 83864		BINE DRIVE NT, ID 83864		0.1	208-263-111		
				2d Business code (see instructions) 336410		е		
Caution	: A penalty for the late or i	incomplete filing of this return/repor	rt will be assessed	unless reasonable caus	e is establis	shed.		
		penalties set forth in the instructions, I as the electronic version of this return						
SIGN HERE	Filed with authorized/valid e	electronic signature.	02/10/2015	HEATHER MYERS				
TILICE	Signature of plan admin	istrator	Date	Enter name of individua	ıl signing as	plan administrator		
SIGN HERE	Filed with authorized/valid	electronic signature.	02/10/2015	SUSAN JORDAN				
	Signature of employer/p	lan sponsor	Date	Enter name of individua	ıl signing as	employer or plan sp	onsor	
SIGN HERE								
	Signature of DFE		Date	Enter name of individua				
-	·	ne, if applicable) and address (include i	room or suite numbe	er) (optional)	Preparer's (optional)	telephone number		
HEATHER MYERS					(Spaintial)	208-263-1111		
QUEST AIRCRAFT COMPANY LLC								
	RBINE DRIVE DINT, ID 83864							
OANDI*(71141, ID 0000 4							

Form 5500 (2014) Page **2**

3a	Plan administrator's name and address Same as Plan Sponsor			3b Admin	istrator's EIN
				3c Admin	istrator's telephone er
4	If the name and/or EIN of the plan sponsor has changed since the last return/re EIN and the plan number from the last return/report:	port filed for th	is 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	129
6	Number of participants as of the end of the plan year unless otherwise stated (w 6a(2), 6b, 6c, and 6d).	velfare plans c	omplete only lines 6a(1),		
a(′) Total number of active participants at the beginning of the plan year			6a(1)	129
a(2	7) Total number of active participants at the end of the plan year			6a(2)	129
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(2), 6b, and 6c.			6d	129
е	Deceased participants whose beneficiaries are receiving or are entitled to receiv	ve benefits		6e	0
f	Total. Add lines 6d and 6e.			6f	129
g	Number of participants with account balances as of the end of the plan year (on complete this item)			6g	
h	Number of participants that terminated employment during the plan year with acless than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only mu			7	
b	If the plan provides pension benefits, enter the applicable pension feature codes If the plan provides welfare benefits, enter the applicable welfare feature codes 4A 4D 4E 4F 4Q	from the List o	of Plan Characteristics Codes	s in the insti	
9a			it arrangement (check all tha	it apply)	
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) (2)	Code section 412(e)(3) i	nsurance c	ontracts
	(3) Trust	(3)	Trust	nourance e	omiaoto
	(4) General assets of the sponsor	(4)	General assets of the sp	onsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attac	ched, and, whe	ere indicated, enter the numb	er attached	d. (See instructions)
а	Pension Schedules	b General S	schedules		
	(1) R (Retirement Plan Information)	(1)	H (Financial Inform	nation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Inform	ation – Sm	all Plan)
	Purchase Plan Actuarial Information) - signed by the plan	(3)	A (Insurance Inform		 ,
	actuary	(4)	C (Service Provide	,	on)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	D (DFE/Participatin		
_	Information) - signed by the plan actuary	(6)	G (Financial Trans	action Sche	edules)
					

Form 5500 (2014) Page **3**

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)				
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes X No					
If "Yes" is checke	If "Yes" is checked, complete lines 11b and 11c.				
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)					
11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 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					

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

2014

					Inspection		
For calendar plan year 20	14 or fiscal pla	an year beginning 01/01/200	8	and en	ding 12	/31/2008	
A Name of plan QUEST AIRCRAFT DESI	A Name of plan QUEST AIRCRAFT DESIGN BENEFITS PLAN				e-digit number (Pl	N) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 QUEST AIRCRAFT DESIGN LLC				D Employer Identification Number (EIN) 82-0535946			
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca							
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a	it end of	(f)	Policy or co	ontract year (g) To
81-0573161	00000	15009371	policy or contrac	t year 29	01/01/20		12/31/2008
	mission inform	nation. Enter the total fees and t					
	•	nmissions paid		(b) To	tal amount	of fees paid	
		0)				0
3 Persons receiving com	missions and	fees. (Complete as many entric	es as needed to report all	persons).			
DANIEL W.TAV(LOD	(a) Name	and address of the agent, broke	•	m commiss	ions or fees	were paid	
DANIEL W TAYLOR			09 W SUPERIOR NDPOINT, ID 83864				
(b) Amount of sales ar	nd base		ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code
	0	0					4
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees	were paid	
	.,	· ·				·	
(b) Amount of sales ar	nd base		ees and other commission				
commissions pa	id	(c) Amount		(d) Purpose	Э		(e) Organization code

Schedule A (Form 5500)	Schedule A (Form 5500) 2014 Page 2 - 1				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

_		
レっへ	Δ	
ıay		•

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contract	s with each carrier may	be treated	d as 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	
_		tracts With Allocated Funds:			•	1
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	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.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Schedule A (Form 5500) 2014	Page 4
	of the same employer(s) or members of the same employee organizations(s), the cracts are experience-rated as a unit. Where contracts cover individual employer by be treated as a unit for purposes of this report.
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 di	isability g Supplemental unemployment h Prescription drug
Stop loss (large deductible) j HMO contrac	ct k PPO contract I Indemnity contract
Other (specify) EMPLOYEE ASSISTANCE PROGRAM	
J (, ,)	
erience-rated contracts:	
Premiums: (1) Amount received	9a(1)
(2) Increase (decrease) in amount due but unpaid	9a(2)
(3) Increase (decrease) in unearned premium reserve	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 (on an accrual basis)	
(A) Commissions	9c(1)(A)
(R) Administrative service or other fees	9c(1)(B)

9c(1)(H)

9c(2)

9d(1)

9d(2)

9d(3)

9e

10a

10b

3115

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) ▶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.....

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

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

(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

Part III

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

9c(1)(C)

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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2014

This Form is Open to Public Inspection

		pursuant to E	RISA section 103(a)(2).			
For calendar plan year 20	14 or fiscal plar	n year beginning 01/01/2008	and	l ending 1	2/31/2008	
A Name of plan QUEST AIRCRAFT DESIGN BENEFITS PLAN				hree-digit olan number (F	PN) •	501
C Plan sponsor's name a QUEST AIRCRAFT DESIGNATION OF THE PROPERTY OF THE PROP		e 2a of Form 5500		nployer Identifi 0535946	ication Number (EIN)
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca						
BLUE CROSS OF IDAHO) HEALTH SEF	RVICE, INC				
/L) [IN]	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f	From	(g) To
82-0344294	60095	10030747	47	01/01/2	8008	12/31/2008
2 Insurance fee and compute descending order of the		ation. Enter the total fees and total	al commissions paid. List in lin	e 3 the agents	s, brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
	27280 144594					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all persons	s).		
		and address of the agent, broker,			s were paid	
BLUE CROSS OF IDAHO) HEALTH AND	O SERV 3000 E MERII	E PINE AVENUE DIAN, ID 83642			
(Is) Assessed of solonous	d b	Fee	s and other commissions paid			
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purpose			(e) Organization code
·		144594 AC	MIN FEES			3
	(a) Nama a	and address of the agent, broker,	or other person to whom comp	niccione or foo	es wore paid	
DANIEL W TAYLOR	(a) Name a		W SUPERIOR	113310113 01 166	s were paid	
BANGE WITH THE ON			POINT, ID 83864			
(b) Amount of sales ar	nd base	Fee	s and other commissions paid			
commissions pai		(c) Amount	(d) Purp	oose		(e) Organization code
	25794	1486 BC	ONUS/OTHER IS A SUM THAT OKER PAYMENT -BEYOND (INCLUDES 2 COMMISSION	2 TYPES OF I.	4

Schedule A (Form 5500)	Schedule A (Form 5500) 2014 Page 2 - 1				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

_		
\mathbf{p}	Δ	
ıay		•

P	art I				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carrier	may be treated as a unit	for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end		
5	Curi	rent value of plan's interest under this contract in separate accounts at year en	nd	5	
6		tracts 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		 	
	d	If the carrier, service, or other organization incurred any specific costs in cor			
		retention of the contract or policy, enter amount.	•	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	dannuity		
		(3) other (specify)			
				<u></u>	
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	= :		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year(4) Transferred from separate account	7c(3) 7c(4)		
		(5) Other (specify below)	7c(5)		
		• Control (Specify Bolow)			
		(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)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Page 4		

10b

		Schedule A (Form 5500) 2014	Pa	age 4		
Pa	art II	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the sinformation may be combined for reporting purposes if such contracts the entire group of such individual contracts with each carrier may be to	are experien	ce-rated as a unit. Where contra		
8	Ben	efit and contract type (check all applicable boxes)				
	а	Health (other than dental or vision)	c	Vision	d 🗌	Life insurance
	е	Temporary disability (accident and sickness) f Long-term disabilit	ty g	Supplemental unemployment	h	Prescription drug
	i	Stop loss (large deductible) j HMO contract	k [PPO contract	ıΠ	Indemnity contract
	m	Other (specify)	_	_		•
	•					
9		erience-rated contracts:		<u> </u>	_	
	а	Premiums: (1) Amount received		102977	<u>′0</u>	
		(2) Increase (decrease) in amount due but unpaid			_	
		(3) Increase (decrease) in unearned premium reserve				
		(4) Earned ((1) + (2) - (3))				102977
	b	Benefit charges (1) Claims paid		87525	<u>51</u>	
		(2) Increase (decrease) in claim reserves				
		(3) Incurred claims (add (1) and (2))				87525
		(4) Claims charged		9b(4)		
	С	Remainder of premium: (1) Retention charges (on an accrual basis)		T	4	
		(A) Commissions	9c(1)(A)	2728	30	
		(B) Administrative service or other fees	- (()(-)	14459	<u>}4</u>	
		(C) Other specific acquisition costs			_	
		(D) Other expenses	9c(1)(D)		_	
		(E) Taxes				
		(F) Charges for risks or other contingencies				
		(G) Other retention charges	9c(1)(G)			
		(H) Total retention		9c(1)(H	1)	17187
		(2) Dividends or retroactive rate refunds. (These amounts were \int paid in	cash, or	credited.) 9c(2)	,	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits afte	r retirement 9d(1)		
		(2) Claim reserves		· · · · · ·		
		(3) Other reserves.				
	е	Dividends or retroactive rate refunds due. (Do not include amount entered				
10) No	nexperience-rated contracts:		,		
		Total premiums or subscription charges paid to carrier		10a		

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

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

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

Specify nature of costs >

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

2014

pursuant to ERISA section 103(a)(2).						Inspection	
For calendar plan year 2014 or fiscal plan year beginning 01/01/2008 and ending 12/31/2008							
A Name of plan QUEST AIRCRAFT DESIG	GN BENEFITS	PLAN	I	B Three-dig plan num	git nber (PN)	501	
C Plan sponsor's name a QUEST AIRCRAFT DESIGNATION OF THE PROPERTY OF THE PROP		e 2a of Form 5500	1	Employer 82-053594	Identification Number 6	(EIN)	
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:	e ochedule A.	marviadar contracto groupea ac	s a unit in r arts ir aria iii ca	ir be reported	on a single concaut	, n.	
(a) Name of insurance ca	rrior						
`,							
DELTA DENTAL OF IDA	HO	T	(-) Annuacinate	h t	Daliana		
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate num persons covered at e			ontract year	
	code	identification number	policy or contract y	ear	(f) From	(g) To	
82-0299431	47791	1472	209	0	1/01/2008	12/31/2008	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. List	in line 3 the a	agents, brokers, and o	other persons in	
(a) Total a	amount of com			(b) Total a	amount of fees paid		
		3524					
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all pe	ersons).			
	(a) Name a	and address of the agent, broke		commissions	or fees were paid		
DANIEL W TAYLOR			9 W SUPERIOR IDPOINT, ID 83864				
(b) Amount of sales ar	nd hase	Fe	ees and other commissions	paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	3524					4	
	(a) Nome	and address of the agent broken	r or other person to whom		ar face were poid	•	
	(a) Name a	and address of the agent, broke	r, or other person to whom	COMMISSIONS	or rees were paid		
(b) Amount of sales ar	nd base	Fe	es and other commissions	paid			
commissions pa		(c) Amount	(d) Purpose		(e) Organization code	

Schedule A (Form 5500) 2014 Page 2 - 1				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	-			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	T			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

_		
レっへ	Δ	
ıay		•

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	be treated	d as 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	
_		tracts With Allocated Funds:			•	1
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	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.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Pa	age 4					
e experien		ere contracts	loyee organizations(s), the cover individual employees,			
c ☐ Vision d ☐ Life insurance g ☐ Supplemental unemployment h ☐ Prescription drug k ☐ PPO contract I ☐ Indemnity contract						
9a(1)		125693				
9a(2)		-125693				
9a(3)		2 (1)				
		9a(4)	0			
9b(1)		111457				
9b(2)		-80094				
		9b(3)	31363			

Pa	art II	If more than one contract covers the same grainformation may be combined for reporting pu	oup of employees of the sarposes if such contracts a	re experienc	ce-rated as a unit. Who	ere contracts c	
_		the entire group of such individual contracts w	vith each carrier may be tro	eated as a u	nit for purposes of this	report.	
8	Ben	efit and contract type (check all applicable boxes)	. 🗖	_	7	_ 1	
	а	Health (other than dental or vision)	b X Dental	С	Vision	d	Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	/ 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	Expe	erience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)		125693	
		(2) Increase (decrease) in amount due but unpaid		9a(2)		-125693	
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))	<u>.</u>			9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)		111457	
		(2) Increase (decrease) in claim reserves		9b(2)		-80094	
		(3) Incurred claims (add (1) and (2))				9b(3)	31363
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or	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	<u> </u>	9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide b	enefits after	retirement	9d(1)	
		(2) Claim reserves		9d(2)			
		(3) Other reserves	9d(3)				
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2)	.)	9e	
10	No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	arrier			10a	
	b	If the carrier, service, or other organization incurrent retention of the contract or policy, other than repo				10b	
		retention of the contract of policy, other than repo	100				

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 >

Schedule A (Form 5500) 2014

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

2014

Pension Benefit Guaranty Co	rporation		s are required to provide to ERISA section 103(a)(2)		on		Inspection
For calendar plan year 2014 or fiscal plan year beginning 01/01/2008 and ending 12/31/2008							
A Name of plan QUEST AIRCRAFT DESIG	GN BENEFITS	S PLAN		B Three plan	e-digit number (Pl	N) •	501
C Plan sponsor's name a QUEST AIRCRAFT DESIG		ne 2a of Form 5500		D Emplo 82-053		cation Number	(EIN)
on a separat	on Conceri e Schedule A.	ning Insurance Contrac Individual contracts grouped a	t Coverage, Fees, as a unit in Parts II and III	nd Comr	nissions orted on a s	Provide inforn ingle Schedule	nation for each contract A.
1 Coverage Information:							
(a) Name of insurance ca	rrier						
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
82-0339119	47783	30000328	102		01/01/20	008	12/31/2008
2 Insurance fee and composite descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
		missions paid		(b) To	tal amount	of fees paid	
		646				-	
3 Persons receiving com	missions and t	fees. (Complete as many entrie	es as needed to report all	persons).			
• r ereene recenting com		and address of the agent, broke			ons or fees	were paid	
DANIEL W TAYLOR		100	9 W SUPERIOR NDPOINT, ID 83864				
(b) Amount of sales ar	nd book	F	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code
	646						4
	(a) Namo	and address of the agent, broke	or or other person to who	m commissi	one or food	wore paid	
	(a) Name	and address of the agent, broke	er, or other person to who	III COITIITIISSI	ons or rees	were paid	
(b) Amount of sales ar	nd base	<u> </u>	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500)	Schedule A (Form 5500) 2014 Page 2 - 1			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	-			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	T			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

_		
レっへ	Δ	
ıay		•

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contract	s with each carrier may	be treated	d as 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	
_		tracts With Allocated Funds:			•	1
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	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.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Page 4		

10a

10b

6458

	Schedule A (Form 5500) 2014		Pa	ge 4			
Part II	Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the urposes if such contracts	are experience	ce-rated as a unit. V	Vhere contrac		
8 Ben	efit and contract type (check all applicable boxes)	_	_	_		_	
а	Health (other than dental or vision)	b Dental	c	Vision		d Life insurance	
е	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental une	mployment	h Prescription drug	
i	Stop loss (large deductible)	j HMO contract	k	PPO contract		Indemnity contract	
m [Other (specify)	- Ц	_			_	
9 Expe	erience-rated contracts:						
a 1	Premiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpai	d	9a(2)				
	(3) Increase (decrease) in unearned premium re-						
	(4) Earned ((1) + (2) - (3))				9a(4)		0
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 (on an accrual basis)				_	
	(A) Commissions		9c(1)(A)				
	(B) Administrative service or other fees		9c(1)(B)				
	(C) Other specific acquisition costs		9c(1)(C)				
	(D) Other expenses		9c(1)(D)				
	(E) Taxes						
	(F) Charges for risks or other contingencies.						
	(G) Other retention charges		9c(1)(G)				
	(H) Total retention				9c(1)(H)		
	(2) Dividends or retroactive rate refunds. (These	e amounts were paid ir	cash, or	credited.)	9c(2)		
d	Status of policyholder reserves at end of year: (*	_					
	(2) Claim reserves	'			9d(2)		
	(3) Other reserves				9d(3)		
е	Dividends or retroactive rate refunds due. (Do n						
10 No	nexperience-rated contracts:	Sincipal		-,			

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	

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.....

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

2014

pursuant to ERISA section 103(a)(2).						
For calendar plan year 20	14 or fiscal pla	n year beginning 01/01/2008		and ending	12/31/2008	
A Name of plan QUEST AIRCRAFT DESI	GN BENEFITS	PLAN	В	Three-digit plan number ((PN) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 QUEST AIRCRAFT DESIGN LLC D Employer Identification N 82-0535946						
		ning Insurance Contract Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca	arrier					
REGENCE LIFE AND HE	EALTH INSURA	ANCE				
	(c) NAIC	(d) Contract or	(e) Approximate numb		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at en policy or contract year		(f) From	(g) To
93-6030398	97985	ID03541I	227	12/01/	2007	11/30/2008
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) Total amount of commissions paid (b) Total amount of fees paid						
-		2701				
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all pers	sons).		
	(a) Name a	and address of the agent, broker		ommissions or fe	es were paid	
DANIEL W TAYLOR			W SUPERIOR STREET IDPOINT, ID 83864			
(b) Amount of sales a	nd base	Fe	es and other commissions p	aid		
commissions pa		(c) Amount	(d)	Purpose		(e) Organization code
	2701					4
	(a) Name a	and address of the agent, broker	r, or other person to whom co	ommissions or fe	es were paid	
(b) Amount of sales a	nd base	Fe	es and other commissions p	aid		
commissions pa		(c) Amount	(d)	Purpose		(e) Organization code

Schedule A (Form 5500)	Schedule A (Form 5500) 2014 Page 2 - 1			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	-			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	T			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

_		
レっへ	Δ	
ıay		•

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contract	s with each carrier may	be treated	d as 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	
_		tracts With Allocated Funds:			•	1
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	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.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Page 4	
nployer(s) or members of the same employer erience-rated as a unit. Where contracts constants a unit for purposes of this report.	

		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	irposes if such contracts a	re experienc	e-rated as a unit. Who	ere contrac		
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	e	Temporary disability (accident and sickness)	f Long-term disability	/ 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	Expe	erience-rated contracts:						
_	•	Premiums: (1) Amount received		9a(1)			=	
		(2) Increase (decrease) in amount due but unpaid	-				=	
		(3) Increase (decrease) in unearned premium res					=	
		(4) Earned ((1) + (2) - (3))	_			9a(4)		0
	_	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves					7	
		(3) Incurred claims (add (1) and (2))	·			9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder 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	<u> </u>	<u></u>		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide b	enefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2)	.)	9e		
10		nexperience-rated contracts:						
	_	Total premiums or subscription charges paid to c				10a		38018
	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 IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	No	

Schedule A (Form 5500) 2014

Welfare Benefit Contract Information

Part III

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 **Service Provider Information**

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2014

This Form is Open to Public Inspection.

Pension Benefit Guaranty Corporation					
For calendar plan year 2014 or fiscal plan year beginning 01	1/01/2008		and ending 12/31/200	3	
A Name of plan		В	Three-digit		
QUEST AIRCRAFT DESIGN BENEFITS PLAN			plan number (PN)	,	501
			<u> </u>		
C Plan sponsor's name as shown on line 2a of Form 5500		D	Employer Identification No	ımber (E	EIN)
QUEST AIRCRAFT DESIGN LLC			82-0535946		
Part I Service Provider Information (see ins	structions)				<u>-</u>
You must complete this Part, in accordance with the instruct or more in total compensation (i.e., money or anything else plan during the plan year. If a person received only eligible answer line 1 but are not required to include that person where the person of the plan of the plan received only eligible and the person of the plan received the required to include that person where the plan received only eligible indirect compensation for which the plan received the required only eligible indirect compensation. Complete as (b) Enter name and EIN or address received LIFE AND HEALTH INSURANCE	e of monetary value) in connection we indirect compensation for which the hen completing the remainder of this gible Indirect Compensation a person from the remainder of this ired disclosures (see instructions for address of each person providing the indirect compensation and its content of the indirect compensation is content of the indirect compensation in the indirect compensation is content of the indirect compensation in the indirect compensation is content of the indirect compensation in the indirect compensation is content of the indirect compensation in the indirect compensation in the indirect compensation is content of the indirect compensation in the indirect compensation in the indirect compensation is content of the indirect compensation in the indirect compensation in the indirect compensation in the indirect compensation is content of the indirect compensation in the indirect compensation in the indirect compensation is content of the indirect compensation in the indirect compensation in the indirect compensation is content of the indirect compensation in the indirect compensation in the indirect compensation in the indirect compensation is content of the indirect compensation in the indirect compens	with the price Pri	services rendered to the plan received the required art. In the because they received of finitions and conditions) In the required disclosures for the required disclosures for the reson eligible indirect correspond	olan or the	ible Providers who
REGENCE LIFE AND HEALTH INSURANCE	PORTLAND, OR 97201	IE /	4		
93-6030398					
(b) Enter name and EIN or addres	ss of person who provided you discl	losu	re on eligible indirect com	pensatio	on
DELTA DENTAL OF IDAHO	PO BOX 2870 BOISE, ID 83701				
82-0299431					
(b) Enter name and EIN or addres	s of person who provided you disclo	osu	res on eligible indirect con	npensati	on
BLUE CROSS OF IDAHO HEALTH SERVICE	3000 EAST PINE AVENUE MERIDIAN, ID 83642				
82-0344294					
(b) Enter name and EIN or addres	s of person who provided you disclo	osu	res on eligible indirect con	npensati	ion

Schedule C (Form 5500) 2014	Page 2- 1
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation

	Schedule C (Form 550	00) 2014		Page 3 - 1		
-				<u> </u>		
answered	f "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation the person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
		(a) Enter name and EIN or	address (see instructions)		
DANIEL W	TAYLOR	·		EST SUPERIOR STREET OINT, ID 83864		
82-048179	9					
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22	BROKER	34151	Yes No X	Yes No X	0	Yes No X
	,	(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
	·	(a) Enter name and EIN or	address (see instructions)	•	
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?

Yes No No

Yes No

Yes No

Page 3 - 2	_
-------------------	---

answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation	
		(a) Enter name and EIN or	address (see instructions)			
(a) the name and the electrical decision							
(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	
		(a) Enter name and EIN or	address (see instructions)			
(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?	
			Yes No	Yes No		Yes No No	
		(a) Enter name and EIN or	address (see instructions)			
(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?	(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?	
			Yes No	Yes No		Yes No	

Part I Service Provider Information (continued)

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 madvestions 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	g services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	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		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 ethe service provider's eligibility the indirect compensation.

Page 5	5-
--------	----

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

Page (6-
--------	----

Pa	rt III Ta	rmination Information on Accountants and Enralled Actuaries (see in	ctructions)
Га	art III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)		
а	Name:	,	b EIN:
С			
d	Address:		e Telephone:
			·
Explanation:			
a	Name:		b EIN:
С	Position:		
d	Address:		e Telephone:
Explanation:			
а	Name:		b EIN:
C	Position:		D LIIV.
d	Address:		e Telephone:
-	7100.000.		· Coopnaid.
Explanation:			
а	Name:		b EIN:
С	Position:		
d	Address:		e Telephone:
Explanation:			
L^	Explanation.		
а	Name:		b EIN:
C	Position:		w = 111.
d	Address:		e Telephone:
-			- 10.0pmono.
Explanation:			