### 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

		entification Information						
For calendar	plan year 2014 or fisc	al plan year beginning 01/01/2014		and ending 12/31/2	2014			
A This return	n/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					
		X a single-employer plan;	a DFE (spec	ify)				
<b>B</b> This return	n/report is:	the first return/report;	the final retu	rn/report;				
		an amended return/report;	a short plan	year return/report (less thar	n 12 month	ns).		
C If the plan	is a collectively-barga	ined plan, check here				. ▶ □		
	k if filing under:	Form 5558;	_	tension;	_	the DFVC program;		
		special extension (enter description	n)					
Part II	Basic Plan Info	rmation—enter all requested informa	ation					
1a Name of GROUP BEN	•	MPLOYEES OF TWIN CITY FOODS, IN	IC.			Three-digit plan number (PN) ▶	508	
					1c	Effective date of plants 03/01/2002	an	
•		ess; include room or suite number (emp	oloyer, if for a single-	-employer plan)	2b	<ul><li>Employer Identification</li><li>Number (EIN)</li></ul>	ition	
TWIN CITY F	OODS, INC.					91-1291675		
					20	Plan Sponsor's tele	ephone	
P.O. BOX 699	9	10120 - 26	69TH PLACE N.W.			number 206-515-2400		
STANWOOD	, WA 98292	STANDW	OOD, WA 98292		<b>2</b> d	2d Business code (see		
						instructions) 311400		
Caution: A n	analty for the late or	incomplete filing of this return/repor	rt will be assessed	unloss roasonable causo	is ostabli	ishad		
Under penalti	es of perjury and othe	er penalties set forth in the instructions, lell as the electronic version of this return	I declare that I have	examined this return/repor	t, including	g accompanying sche		
Statements at	id attacriments, as we	as the electronic version of this return		lest of fifty knowledge and b	eller, it is t	ilde, correct, and con	ipiete.	
SIGN Filed	d with authorized/valid	electronic signature.	06/29/2015	SUSAN CASTEEL				
HERE Sig	nature of plan admir	nistrator	Date	Enter name of individual	al signing as plan administrator			
SIGN								
HERE Sig	nature of employer/	plan sponsor	Date	Enter name of individual	signing as	s employer or plan sp	onsor	
SIGN HERE								
Sig	nature of DFE		Date	Enter name of individual	signing as	s DFE		
Preparer's na	me (including firm nar	me, if applicable) and address (include i	room or suite numbe	,		telephone number		
(орнол					(optional)			
For Paperwo	ork Reduction Act No	otice and OMB Control Numbers, see	the instructions for	or Form 5500.		Form 5500	(2014)	

Form 5500 (2014) Page **2** 

3a	Plan administrator's name and address Same as Plan Sponsor					ninistrator's EIN -1291675
	TWIN CITY FOODS, INC.					ninistrator's telephone
	D. BOX 699 ANDWOOD, WA 98292					nber 206-515-2400
4	If the name and/or EIN of the plan sponsor has changed since the last return/rep EIN and the plan number from the last return/report:	oort filed fo	r this	olan, enter the name,	4b EIN	
а	Sponsor's name				4c PN	
5	Total number of participants at the beginning of the plan year				5	360
6	Number of participants as of the end of the plan year unless otherwise stated (we <b>6a(2), 6b, 6c,</b> and <b>6d</b> ).	elfare plar	ns com	plete only lines 6a(1)	),	
a(′	) Total number of active participants at the beginning of the plan year				6a(1)	360
a(2	Total number of active participants at the end of the plan year				6a(2)	359
b	Retired or separated participants receiving benefits				6b	2
С	Other retired or separated participants entitled to future benefits				6с	0
d	Subtotal. Add lines 6a(2), 6b, and 6c.				6d	361
е	Deceased participants whose beneficiaries are receiving or are entitled to receive	e benefits			6е	
f	Total. Add lines <b>6d</b> and <b>6e</b> .				6f	
g	Number of participants with account balances as of the end of the plan year (only complete this item)				6g	
h	Number of participants that terminated employment during the plan year with access than 100% vested				6h	
7	Enter the total number of employers obligated to contribute to the plan (only mult					
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 f  4A 4B 4D 4E 4F 4H	from the Li	st of F	rlan Characteristics C	codes in the in	
9a	Plan funding arrangement (check all that apply)  (1) Insurance	<b>b</b> Plan be <b>(1)</b>	enefit a	arrangement (check a Insurance	all that apply)	
	Code section 412(e)(3) insurance contracts	(2)		Code section 412(e	e)(3) insurance	contracts
	(3) Trust	(3)	_	Trust General assets of the	ho anoncor	
10	(4) X General assets of the sponsor  Check all applicable boxes in 10a and 10b to indicate which schedules are attack	(4)	^ where		•	ed. (See instructions)
2		b Gener				,
а	(1) R (Retirement Plan Information)	(1)		H (Financial I	nformation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money			I (Financial Ir	·	mall Plan)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(2) (3)	X	_4 A (Insurance		illalı Flali)
	actuary	(4)		C (Service Pr	,	ation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)		D (DFE/Partic	-	
	Information) - signed by the plan actuary	(6)		G (Financial T	ransaction So	medules)

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.)					
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 Confirma	ation Code				

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 20°	14 or fiscal pla	n year beginning 01/01/2014		and en	ding 12	2/31/2014		
A Name of plan GROUP BENEFITS PLAN FOR EMPLOYEES OF TWIN CITY FOODS, INC.  B Three-digit plan number (PN)						N) •	508	
C Plan sponsor's name as shown on line 2a of Form 5500 TWIN CITY FOODS, INC.  D Employer Identification Number (EIN) 91-1291675							EIN)	
	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	rrier							
STANDARD INSURANCI	E COMPANY							
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			Policy or co	ntract year	
(b) Liiv	code	identification number	policy or contrac		(f)	) From	<b>(g)</b> To	
93-0242990	69019	322951	3:	59	01/01/20	014	12/31/2014	
	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 a	(a) Total amount of commissions paid (b) Total amount of fees paid							
0								
3 Persons receiving com		ees. (Complete as many entrie						
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	s were paid		
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid				
commissions pai		(c) Amount	(d) Purpose				(e) Organization code	
	(a) Name a	and address of the agent, broke	r. or other person to who	m commissi	ions or fees	s were paid		
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid	-			
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code	

Schedule A (Form 5500) 2014 Page <b>2 -</b> 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				
<b>(a)</b> 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				
<b>(a)</b> 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							
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such 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 <b>7b</b> and <b>7c(6)</b> ).			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 <b>7e(5)</b> from line <b>7d</b> )			7f	

Page <b>4</b>	

Pa	ırt l				(-)			41
		If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	urposes if such contracts	are experienc	e-rated as a unit. Whe	ere contract		
8	Ben	efit and contract type (check all applicable boxes)	)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> X Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	ty <b>g</b>	Supplemental unemp	loyment	h Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		Indemnity contract	:t
	m	X Other (specify) ACCIDENTAL DEATH & DI	SMEMBERMENT				_	
9	Ехр	erience-rated contracts:						
	а	Premiums: (1) Amount received		9a(1)		72138		
		(2) Increase (decrease) in amount due but unpai	d	9a(2)		896		
		(3) Increase (decrease) in unearned premium res	serve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		73034
	b	Benefit charges (1) Claims paid		9b(1)		129000		
		(2) Increase (decrease) in claim reserves		9b(2)		-4		
		(3) Incurred claims (add (1) and (2))				9b(3)		128996
		(4) Claims charged				9b(4)		128996
	С	Remainder of premium: (1) Retention charges (0	on an accrual basis)	1				
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees						
		(C) Other specific acquisition costs						
		(D) Other expenses				9254		
		(E) Taxes				1461		
		(F) Charges for risks or other contingencies.		9c(1)(F)		5113		
		(G) Other retention charges			T			
		(H) Total retention			•	9c(1)(H)		15828
		(2) Dividends or retroactive rate refunds. (These	e amounts were 📗 paid in	cash, or	credited.)	9c(2)		0
	d	Status of policyholder reserves at end of year: (1	1) Amount held to provide	benefits after	retirement	9d(1)		0
		(2) Claim reserves				9d(2)		166765
		(3) Other reserves				9d(3)		0
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2)	.)	9e		0
10	No	onexperience-rated contracts:			r			
	а	Total premiums or subscription charges paid to carrier						
	b	If the carrier, service, or other organization incur				405		
		retention of the contract or policy, other than rep	orted in Part I, line 2 abov	e, report amo	ount	10b		
	S	pecify 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	

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2014

pursuant to ERISA section 103(a)(2).					inspection		
For calendar plan year 20	14 or fiscal plar	n year beginning 01/01/2014		and en	ding 12	2/31/2014	
A Name of plan GROUP BENEFITS PLAN	FOR EMPLO	YEES OF TWIN CITY FOODS,	INC.	B Three-digit plan number (PN) 508			
C Plan sponsor's name a TWIN CITY FOODS, INC.	s shown on line	e 2a of Form 5500		<b>D</b> Emplo 91-129		cation Number (	EIN)
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	rrier						
LIFE INSURANCE COMP	PANY OF NOR	TH AMERICA					
(In) FINI	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
23-1503749	65498	OK-004627		33	01/01/20	014	12/31/2014
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	, brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
0							
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	nd address of the agent, broke	r, or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount	<b>(d)</b> Pu		) Purpose		(e) Organization code
	(a) Name a	nd address of the agent, broke	r, or other person to who	m commissi	ions or fees	s were paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code

Schedule A (Form 5500) 2014 Page <b>2 -</b> 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		
<b>(a)</b> 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		
<b>(a)</b> 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		

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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 <b>7b</b> and <b>7c(6)</b> ).			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 <b>7e(5)</b> from line <b>7d</b> )			7f	

Schedule A (Form 5500) 2014		Page <b>4</b>	ļ	
rt III Welfare Benefit Contract Infor If more than one contract covers the sar information may be combined for reporti the entire group of such individual contra	ne group of employees of the ng purposes if such contracts	are experience-ra	ted as a unit. Where contract	
Benefit and contract type (check all applicable bo	ixes)			
a Health (other than dental or vision)	<b>b</b> Dental	<b>c</b> Vis	sion	<b>d</b> Life insurance
e Temporary disability (accident and sickness	ss) <b>f</b> Long-term disabili	ty <b>g</b> ☐ Su	pplemental unemployment	h Prescription drug
i Stop loss (large deductible)	j HMO contract		O contract	I Indemnity contract
m X Other (specify) ▶VOLUNTARY AD&D	, <u>u</u>	ш		ь .
Experience-rated contracts:				
a Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but u	npaid	9a(2)		
(3) Increase (decrease) in unearned premiur	n reserve	9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)	
<b>b</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)	
c Remainder of premium: (1) Retention charg	es (on an accrual basis)			
(A) Commissions		9c(1)(A)		
(B) Administrative service or other fees.				
(C) Other specific acquisition costs		9c(1)(C)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

3630

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)

(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.).....

(2) Claim reserves .....

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

Total premiums or subscription charges paid to carrier ......

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

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

Part III

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

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

9c(1)(F)

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2014

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 20	114 or fiscal pla	an year beginning 01/01/2014		and end	ding 12/	31/2014	
A Name of plan GROUP BENEFITS PLAN	N FOR EMPLO	DYEES OF TWIN CITY FOODS,	INC.	B Three plan	e-digit number (PN	I) <b>&gt;</b>	508
C Plan sponsor's name a TWIN CITY FOODS, INC		ne 2a of Form 5500		D Employ 91-129		ation Number	(EIN)
		ning Insurance Contract  Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	arrier						
STANDARD INSURANC	E COMPANY						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nun persons covered at	-		Policy or c	ontract year
(b) EIN	code	identification number	policy or contract y		(f)	From	<b>(g)</b> To
93-0242990	69019	322951	94		01/01/201	14	12/31/2014
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	tal commissions paid. Lis	t in line 3 t	the agents, b	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		0					0
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all pe	ersons).			
	(a) Name	and address of the agent, broker	r, or other person to whom	commissi	ions or fees	were paid	
(b) Amount of sales a	nd base	Fe	es and other commissions	paid			
commissions pa		(c) Amount	(d) Purpose				(e) Organization code
	(a) Name	and address of the agent, broker	r or other person to whom	commissi	ions or fees	were paid	
	(a) Hamo	and address of the agent, protest	, or other percent to when	00111111001	10110 01 1000	noro para	
(b) Amount of sales a	nd base	Fe	es and other commissions	paid			
commissions pa		(c) Amount	(0	) Purpose	9		(e) Organization code

Schedule A (Form 5500) 2014 Page <b>2 -</b> 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		
<b>(a)</b> 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		
<b>(a)</b> 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		

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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 <b>7b</b> and <b>7c(6)</b> ).			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 <b>7e(5)</b> from line <b>7d</b> )			7f	

Page	4

Pa	art II	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 of employees of the surposes if such contracts	are experience	ce-rated as a unit. Who	ere contracts	
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision	(	d Life insurance
	е	Temporary disability (accident and sickness)	f X Long-term disabili	ty <b>g</b>	Supplemental unemp	oloyment	h Prescription drug
	i	Stop loss (large deductible)	i HMO contract	k	PPO contract		I  Indemnity contract
	m	Other (specify)			1		ь ,
	[						
9	Ехр	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)		33840	
		(2) Increase (decrease) in amount due but unpaid	ł	9a(2)		5	
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	33845
	b	Benefit charges (1) Claims paid		· · · · ·		28466	
		(2) Increase (decrease) in claim reserves				-12420	
		(3) Incurred claims (add (1) and (2))				9b(3)	16046
	_	(4) Claims charged				9b(4)	16046
	С	Remainder of premium: (1) Retention charges (o	,	0=/4\/A\			_
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		2 (4)(2)			_
		(C) Other specific acquisition costs(D) Other expenses		9c(1)(D)		6247	_
		(E) Taxes		9c(1)(E)		677	-
		(F) Charges for risks or other contingencies		9c(1)(F)		4062	-
		(G) Other retention charges		2 (1)(2)		6813	_
		(H) Total retention				9c(1)(H)	17799
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or X	credited.)	9c(2)	11125
	d	Status of policyholder reserves at end of year: (1				9d(1)	0
		(2) Claim reserves				9d(2)	138098
		(3) Other reserves				9d(3)	0
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line <b>9c(2)</b>	.)	9e	0
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c				10a	
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo			•	10b	
	Sp	pecify nature of costs		•			

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

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2014

, , , , , , , , , , , , , , , , , , , ,		D ERISA section 103(a)(2).			Inspection		
For calendar plan year 20°	14 or fiscal pla	an year beginning 01/01/2014	, , , , , , , , , , , , , , , , , , ,	and en	ding 12/31/2014		
A Name of plan GROUP BENEFITS PLAN FOR EMPLOYEES OF TWIN CITY FOODS,			INC.	B Three plan	e-digit number (PN)	508	
C Plan sponsor's name a TWIN CITY FOODS, INC.		ne 2a of Form 5500		<b>D</b> Emplo	yer Identification Number 01675	(EIN)	
on a separat		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
VISION SERVICE PLAN							
	(c) NAIC	(d) Contract or	(e) Approximate n	(e) Approximate number of persons covered at end of policy or contract year		ontract year	
<b>(b)</b> EIN	code	identification number				<b>(g)</b> To	
91-6056925	47317	12252119		76	01/01/2014	12/31/2014	
2 Insurance fee and composite descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers, and o	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
		0				0	
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees were paid		
(b) Amount of sales and base Fees and other commissions paid							
commissions paid		(c) Amount		(d) Purpose		(e) Organization code	
	(-) N	and address of the arrest banks			'		
	(a) Name	and address of the agent, broke	r, or otner person to wno	m commiss	ions or tees were paid		
(b) Amount of sales ar	nd base	Fees and other comm		ssions paid			
commissions pai		(c) Amount		(d) Purpose	Э	(e) Organization code	

Schedule A (Form 5500) 2014 Page <b>2 -</b> 1							
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid					
	-						
(b) Amount of sales and base	punt of sales and base Fees and other commissions paid						
commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
(a) No	uma and addraga of the agent broke	The season to whom commissions as focus were noid					
(a) Na	arne and address of the agent, broke	er, or other person to whom commissions or fees were paid					
		Eggs and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code				
COMMISSIONS PAID	(c) Amount	(u) i dipose					
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid					
(b) Amount of sales and base		(e) Organization					
commissions paid (c) Amount		(d) Purpose	code				
(a) No	uma and address of the agent, broke	er, or other person to whom commissions or fees were paid					
(a) No	ine and address of the agent, broke	er, or other person to whom commissions or rees were paid					
		Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
	(c) / unount	(a) a speed					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid					
	<del>,</del>						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

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Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	ridual 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					
	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	aintained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatic	n 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 <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7-(4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			7f	

Schedule A (Form 5500) 2014	Page <b>4</b>
	e same employer(s) or members of the same employee organizations(s), the sare experience-rated as a unit. Where contracts cover individual employees, e treated as a unit for purposes of this report.
efit and contract type (check all applicable boxes)	
Health (other than dental or vision) <b>b</b> Dental	<b>c</b> ☒ Vision <b>d</b> ☐ Life insurance
Temporary disability (accident and sickness) <b>f</b> Long-term disabil	ility $\mathbf{g} \ \square$ Supplemental unemployment $\mathbf{h} \ \square$ Prescription drug
Stop loss (large deductible) j HMO contract	k ☐ PPO contract I ☐ Indemnity contract
Other (specify) VOLUNTARY VISION	
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))	
Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `
(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)

10b

Benefit charges (1) Claims paid..... (2) Increase (decrease) in claim reserves..... (3) Incurred claims (add (1) and (2)) ...... (4) Claims charged ..... Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions ..... (B) Administrative service or other fees..... 9c(1)(B) 9c(1)(C) (C) Other specific acquisition costs ..... (D) Other expenses..... 9c(1)(D) 9c(1)(E) (E) Taxes..... 9c(1)(F) (F) Charges for risks or other contingencies..... 9c(1)(H) (H) Total retention..... (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)..... 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement ...... 9d(1) (2) Claim reserves ..... 9d(2) (3) Other reserves..... 9d(3) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... 9e 10 Nonexperience-rated contracts: 10a Total premiums or subscription charges paid to carrier ...... 15979 If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

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

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

m X Other (specify) ▶ VOLUNTARY VISION

Experience-rated contracts:

Specify nature of costs

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

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

Part III

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