Form 5500	Annual Return/Report of Employee Benefit Plan			OMB Nos. 1210-0110		
101110000	This form is required to be filed for employee benefit plans under sections 104		1210-0089			
Department of the Treasury Internal Revenue Service		nt Income Security Act of 1974 (ERISA) and a) of the Internal Revenue Code (the Code).		2014		
Department of Labor Employee Benefits Security Administration	•	tries in accordance with ns to the Form 5500.				
Pension Benefit Guaranty Corporation			This	Form is Open to Pu Inspection	ıblic	
Part I Annual Report Ider	ntification Information					
For calendar plan year 2014 or fiscal		and ending 12/31/20)14			
A This return/report is for:	a multiemployer plan;	a multiple-employer plan (Filers checking participating employer information in acco			ons); or	
	🗙 a single-employer plan;	a DFE (specify)				
B This return/report is:	\times the first return/report;	the first return/report;				
	an amended return/report;	a short plan year return/report (less than 12 months).				
C If the plan is a collectively-bargain	ed plan, check here			•		
D Check box if filing under:	× Form 5558;	automatic extension;	the DFVC program;			
Ŭ .	special extension (enter description)					
Part II Basic Plan Infor	mation—enter all requested information	on				
1a Name of plan PAINE ELECTRONICS, LLC HEALT			1b	Three-digit plan number (PN) ►	501	
			1c	Effective date of pla 01/01/2014	ิลท	
2a Plan sponsor's name and addres	ss; include room or suite number (emplo	yer, if for a single-employer plan)	2b	Employer Identifica	tion	
PAINE ELECTRONICS, LLC.				Number (EIN) 91-1699463		
JODIE HALL			2c	Plan Sponsor's tele number	phone	
5545 NELPAR DRIVE	5545 NELPA			509-881-2100)	
EAST WENATCHEE, WA 98802	EAST WEN	ATCHEE, WA 98802	2d Business code (see instructions) 334500		;	

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN	Filed with authorized/valid electronic signature.	07/29/2015	JODIE HALL				
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator				
SIGN HERE	Filed with authorized/valid electronic signature.	07/29/2015	JODIE HALL				
HERE	Signature of employer/plan sponsor	Date	Enter name of individu	al signing as employer or plan sponsor			
SIGN HERE							
	Signature of DFE	Date	Enter name of individu	al signing as DFE			
Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional) Preparer's telephone number (optional)							
For Pap	For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.						

Page **2**

3a	Plan administrator's name and address XSame as Plan Sponsor		3b Administrator's EIN		
			ministrator's telephone mber		
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name,	4b EII	N		
•	EIN and the plan number from the last return/report:		47-1799759		
RC	Sponsor's name DSEMOUNT SPECIALTY PRODUCTS, LLC.	4c pn	501		
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 (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).				
a(1) Total number of active participants at the beginning of the plan year	6a(1)	104		
a(2	2) Total number of active participants at the end of the plan year	6a(2)	100		
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	100		
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	0		
f	Total. Add lines 6d and 6e.	6f	100		
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	0		
	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	0		
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	100		
8a	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Code	es in the	instructions:		

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4H 4L

9a	9a Plan funding arrangement (check all that apply)				9b Plan benefit arrangement (check all that apply)				
	(1)	X	Insurance	(1) X Insurance				Insurance	
	(2)		Code section 412(e)(3) insurance contracts		(2)			Code section 412(e)(3) insurance contracts	
	(3)		Trust		(3)			Trust	
	(4)	X	General assets of the sponsor		(4)	X		General assets of the sponsor	
10	Check	all ap	plicable boxes in 10a and 10b to indicate which schedules are at	tache	d, and,	whe	re i	indicated, enter the number attached. (See instructions)	
а	Pensic	on Sc	hedules	b General Schedules					
	(1)		R (Retirement Plan Information)		(1)]	H (Financial Information)	
	(2)	Π	MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	Γ	1	I (Financial Information – Small Plan)	
			Purchase Plan Actuarial Information) - signed by the plan		(3)	X	(<u>3</u> A (Insurance Information)	
			actuary		(4)			C (Service Provider Information)	
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		(5)			D (DFE/Participating Plan Information)	
					(6)			G (Financial Transaction Schedules)	

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 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_

SCHEDULE	A	Insuran	ce Informatio	n		ON	/B No. 1210-0110
(Form 5500		This schedule is require	d to be filed under costi	op 101 of th			2014
Department of the Treas Internal Revenue Serv		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2014
Department of Labo Employee Benefits Security Ad		File as an attachment to Form 5500.					
Pension Benefit Guaranty Co	prporation	 Insurance companies pursuant to 	are required to provide t ERISA section 103(a)(2)		ion	This Fo	rm is Open to Public Inspection
For calendar plan year 20	14 or fiscal pla	n year beginning 01/01/2014		and en	iding 12	2/31/2014	
A Name of plan PAINE ELECTRONICS, L	LC HEALTH A	ND WELFARE PLAN			e-digit number (P	N) 🕨	501
C Plan sponsor's name a PAINE ELECTRONICS, L		e 2a of Form 5500		D Emplo 91-169		cation Number	(EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
UNITED HEALTHCARE	INSURANCE C	COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	contract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
36-2739571	79413	0901803	1:	29	01/01/20)14	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3.	the agents,	brokers, and o	other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount	of fees paid	
		25227					0
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all	persons).			
		and address of the agent, broker		m commiss	ions or fees	s were paid	
HUB INTERNATIONAL N	NORTHWEST		3OX 3018 HELL, WA 98041-3018				
(b) Amount of sales ar	nd base	Fe	es and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) Purpos	e		(e) Organization code
	25227						3
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	ions or fees	s were paid	
		Γ.	os and other commissio				

(b) Amount of sales and base							
commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
East David and David and Ast Matter	an Demonstrate Devices for Act Nation and OND Constrat New Long and the instructions for France 5500						

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2014 v. 140124

(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				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (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					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			l
			1

(a) Name and address of the agent, broker, 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

Page 3

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of						
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	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			6c	
	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	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st		shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	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)			
		•				
	f	(5) Total deductions				

	Schedule A (Form 5500) 2014		Page 4	
Part	III Welfare Benefit Contract Information If more than one contract covers the same group information may be combined for reporting put the entire group of such individual contracts w	oup of employees of the same en rposes if such contracts are exp	erience-rated as a unit. Where contra	
a e i	 Health (other than dental or vision) Temporary disability (accident and sickness) Stop loss (large deductible) Other (specify) 	 b Dental f Long-term disability j HMO contract 	C Vision Supplemental unemployment PPO contract	d Life insurance h Prescription drug I Indemnity contract
•	perience-rated contracts: Premiums: (1) Amount received			_

а	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)	
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			
	(C) Other specific acquisition costs			
	(D) Other expenses	9c(1)(D)		
	(E) Taxes			
	(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 ir			
d				
	(2) Claim reserves		9d(2)	
	(3) Other reserves			
е				
	Vonexperience-rated contracts:			
a			. 10a	504547
b				00001
	retention of the contract or policy, other than reported in Part I, line 2 abov	•	. 10b	

Specify nature of costs

Part IV Provision of Information

11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12	If the answer to line 11 is "Yes," specify the information not provided.			

	•	luouron					
	SCHEDULE A Insurance Information			OMB No. 1210-0110			
(Form 5500 Department of the Treas Internal Revenue Servi	ury	This schedule is required Employee Retirement Inc				2014	
Department of Labor Employee Benefits Security Adr		 File as an attachment to Form 5500. 					
Pension Benefit Guaranty Co		 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		ion	This Fo	orm is Open to Public Inspection
For calendar plan year 20 ⁴	14 or fiscal plar	•		, and en	ding 12	/31/2014	
A Name of plan PAINE ELECTRONICS, LLC HEALTH AND WELFARE PLAN B Three-digit plan number (PN)					N) 🕨	501	
	C Plan sponsor's name as shown on line 2a of Form 5500 PAINE ELECTRONICS, LLC. D Employer Identification Number (EIN) 91-1699463					r (EIN)	
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
THE LINCOLN NATIONA	L LIFE INSUR	ANCE COMPANY					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of		(f)	Policy or contract year) From (g) To	
35-0472300	65676	000010170937	policy or contrac	t year	01/01/20		12/31/2014
2 Insurance fee and com	l nission informa	ation. Enter the total fees and tota					
descending order of the	amount paid. amount of comr	missions naid		(b) To	otal amount	of fees paid	
(a) rotare		2027					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
Ŭ		nd address of the agent, broker,	•	. ,	ions or fees	were paid	
HUB INTERNATIONAL N	IORTHWEST L		DX 3018 IELL, WA 98041-3018				
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpose		(e) Organization code	
	2027						3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
						·	

(b) Amount of sales and base	ŀ					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
For Panarwork Paduction Act Nation and OMR Control Numbers, son the instructions for Form 5500						

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2014 v. 140124

(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				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (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		(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		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			l
			1

(a) Name and address of the agent, broker, 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

Page 3

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a u					as a unit for purposes of	
		this report.			,	
		ent value of plan's interest under this contract in the general account at year				
-		ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Con	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			6c	
	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	annuity			
		(3) other (specify)				
	4	Management was a base of the state of the st	- Constant	shaalahaa N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts main				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee		
		(3) guaranteed investment (4) dother ►				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	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)			
		•				
	f	(5) Total deductions				

Page **4**

Ра	art II	I 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 purposes if such contracts	are experien	ce-rated as a unit. Wh	ere contrac	
8	Ben	efit and contract type (check all applicable boxes))				
	a	Health (other than dental or vision)	b Dental	с	Vision		d X Life insurance
	еĪ	Temporary disability (accident and sickness)	f 🛛 Long-term disabili	ity g	Supplemental unem	olovment	h Prescription drug
	ιĒ	Stop loss (large deductible)	j 🗍 HMO contract		PPO contract		I Indemnity contract
	• L m [· _			
	m	▼ Other (specify) ▲ACCIDENTAL DEATH AND	DISIVIEIVIDERIVIEINI				
9	Fxpe	erience-rated contracts:					
-	•	Premiums: (1) Amount received		. 9a(1)			-
		(2) Increase (decrease) in amount due but unpai					-
		(3) Increase (decrease) in unearned premium re-					1
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		. 9b(1)			
		(2) Increase (decrease) in claim reserves		. 9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (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.					_
		(G) Other retention charges					
		(H) Total retention	_			9c(1)(H)
		(2) Dividends or retroactive rate refunds. (These		L1		/	
	d	Status of policyholder reserves at end of year: (Amount held to provide 	benefits afte	r retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do r	not include amount entere	d in line 9c(2)] .)	9e	
10	No	nexperience-rated contracts:				r	
	a	Total premiums or subscription charges paid to				10a	1351
	b	If the carrier, service, or other organization incur				10b	
		retention of the contract or policy, other than rep	oneu în Part I, line 2 abov	ve, report am	ourit		

Specify nature of costs

Part IV Provision of Information

11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No
12	If the answer to line 11 is "Yes," specify the information not provided.		

SCHEDULE	A	Insuran	ce Informatio	n		_	
(Form 5500)						MB No. 1210-0110	
Department of the Treas Internal Revenue Serv	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).				2014	
Department of Labo Employee Benefits Security Ad		File as an	attachment to Form 55	600.			
Pension Benefit Guaranty Co	orporation	 Insurance companies pursuant to 	are required to provide t ERISA section 103(a)(2)		ion	This Fo	orm is Open to Public Inspection
For calendar plan year 20	14 or fiscal pla	an year beginning 01/01/2014		and en	iding 12	/31/2014	
A Name of plan PAINE ELECTRONICS, L	LC HEALTH A	AND WELFARE PLAN			e-digit number (Pl	N) 🕨	501
C Plan sponsor's name a PAINE ELECTRONICS, L		ne 2a of Form 5500		D Emplo 91-169		ation Numbe	r (EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	arrier						
VISION SERVICE PLAN							
(b) EIN (c) NAIO code		(d) Contract or	.,	Approximate number of		Policy or	contract year
		identification number	persons covered a policy or contrac		(T)		(g) To
23-7089668 53031		30045055	10	100 01/0		14	12/31/2014
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total :	amount of corr	nmissions paid		(b) To	otal amount	of fees paid	
		734					
3 Persons receiving com		fees. (Complete as many entries	•	. ,			
HUB INTERNATIONAL N	. ,		r, or other person to who BOX 3018 HELL, WA 98041-3018	m commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	Fe	es and other commission	ns paid			_
commissions pa	id	(c) Amount		(d) Purpose			(e) Organization code
	734						3
	(a) Name	and address of the agent, broker	r, or other person to who	m commiss	ions or fees	were paid	

(b) Amount of sales and base	ł				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
For Panerwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500					

Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. ⊢or

Schedule A (Form 5500) 2014 v. 140124

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

I	(e) Organization	
(c) Amount	(d) Purpose	code
ame and address of the agent broke	r or other person to whom commissions or fees were paid	
	(c) Amount	Fees and other commissions paid (c) Amount (d) Purpose ame and address of the agent, broker, or other person to whom commissions or fees were paid

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (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				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base		(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		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Page 3

Ρ	Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may		v be treated	as a unit for purposes of		
		this report.			,	
		rent value of plan's interest under this contract in the general account at year			. 4	
5		rent value of plan's interest under this contract in separate accounts at year en	nd		. 5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b				Ch	
	b	Premiums paid to carrier			. 6b	
	с С	Premiums due but unpaid at the end of the year If the carrier, service, or other organization incurred any specific costs in cor			. 6c	
	d	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) ☐ other (specify) ►				
	f	If contract purchased in whole or in part to distribute herefits from a termin	oting plan			
7		If contract purchased, in whole or in part, to distribute benefits from a termin				
'		tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	lion guarantee		
		(3) guaranteed investment (4) dother ►				
	_					
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
					- (-)	
		(6)Total additions			. 7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))	 1		. 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) 7e(4)			
		(4) Other (specify below)	. / e(4)			
		7				
		(5) Total deductions			. 7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			. 7f	

m Other (specify) ▶

		Schedule A (Form 5500) 2014		Page 4	
Pa	art III	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting put the entire group of such individual contracts	roup of employees of the same er urposes if such contracts are exp	erience-rated as a unit. Where contra	
8	Benefit	and contract type (check all applicable boxes)			
	a 🛛 I	Health (other than dental or vision)	b Dental	c 🔀 Vision	d Life insurance
	e 🗌 1	Temporary disability (accident and sickness)	f Long-term disability	g Supplemental unemployment	h Prescription drug
	i 🗌 🤋	Stop loss (large deductible)	j 🔲 HMO contract	k PPO contract	I Indemnity contract

9 Ex	xperience-rated contracts:			
а	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)	
l	D 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)		
	(B) Administrative service or other fees			
	(C) Other specific acquisition costs			
	(D) Other expenses	9c(1)(D)		
	(E) Taxes	9c(1)(E)		
	(F) Charges for risks or other contingencies	9c(1)(F)		
	(G) Other retention charges	9c(1)(G)		
	(H) Total retention	·····	9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These amounts were pa	aid in cash, or 🗌 credited.)		
	d Status of policyholder reserves at end of year: (1) Amount held to prov			
	(2) Claim reserves			
	(3) Other reserves			
	 Dividends or retroactive rate refunds due. (Do not include amount entities) 			
10	Nonexperience-rated contracts:	(_/)		
-	a Total premiums or subscription charges paid to carrier		10a	9684
	If the carrier, service, or other organization incurred any specific costs			0004
	retention of the contract or policy, other than reported in Part I, line 2 a		10b	
	Specify nature of costs	-	<u> </u>	

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

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