Form 5500	Annual Return/Report of Employee Benefit Plan			OMB Nos. 12	10-0110 10-0089	
Department of the Treasury Internal Revenue Service	and 4065 of the Employee Retirem	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).				
Department of Labor Employee Benefits Security Administration		 Complete all entries in accordance with the instructions to the Form 5500. 		2014		
Pension Benefit Guaranty Corporation			This	Form is Open to Pu Inspection	ıblic	
	ntification Information					
For calendar plan year 2014 or fiscal	plan year beginning 01/01/2014	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	
	X a single-employer plan;	a DFE (specify)				
B This return/report is:	X the first return/report;	the first return/report; the final return/report;				
·	an amended return/report; a short plan year return/report (less than 1			ו 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 DF	VC program;		
Ŭ	special extension (enter descriptio	n)				
Part II Basic Plan Infor	mation—enter all requested information	ation				
1a Name of plan THE TERTELING CO., INC. GROUF			1b	Three-digit plan number (PN) ▶	501	
			1c	Effective date of pla 04/01/1978	an	
2a Plan sponsor's name and addres THE TERTELING CO., INC.	ss; include room or suite number (emp	bloyer, if for a single-employer plan)	2b	Employer Identifica Number (EIN) 82-0180520	tion	
3858 N. GARDEN CENTER WAY		ARDEN CENTER WAY	2c	Plan Sponsor's tele number 208-381-5205		
STE. 300 BOISE, ID 83703	STE. 300 BOISE, ID 83703		2d Business code (see instructions) 551112)	

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 HERE	Filed with authorized/valid electronic signature.	07/20/2015	FLINDA TERTELING			
	Signature of plan administrator	Date	Enter name of individu	al signing as plan administrator		
SIGN HERE	Filed with authorized/valid electronic signature.	07/20/2015	FLINDA TERTELING			
HERE	Signature of employer/plan sponsor	Date	Enter name of individu	al signing as employer or plan sponsor		
SIGN HERE						
NEKE	Signature of DFE	Date	Enter name of individu	nter name of individual signing as DFE		
Prepare	's name (including firm name, if applicable) and address (include r	oom or suite numbe				
KIMBER	LYIMEHEN			(optional)		
THE TERTELING CO., INC.						
3858 N. STE, 30	GARDEN CENTER WAY					

3a	Plan administrator's name and address Same as Plan Sponsor	3b Administrator's EIN			
			ninistrator's telephone nber		
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, EIN and the plan number from the last return/report:	4b EIN	l		
а	Sponsor's name	4c PN			
5	Total number of participants at the beginning of the plan year	5	896		
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(*	I) Total number of active participants at the beginning of the plan year	. 6a(1)	828		
a(2) Total number of active participants at the end of the plan year	. 6a(2)	862		
b	Retired or separated participants receiving benefits	. 6b	64		
С	Other retired or separated participants entitled to future benefits	. 6c			
d	Subtotal. Add lines 6a(2), 6b, and 6c.	. 6d	926		
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	. 6e			
f	Total. Add lines 6d and 6e.	. 6f	926		
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	. 6g			
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	. 6h			
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	· 7			
8a	If the plan provides pension hanafits, onter the applicable pension feature codes from the List of Plan Characteristics Cod	as in tha i	nstructions:		

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes 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	a Plan funding arrangement (check all that apply)				9b Plan benefit arrangement (check all that apply)				
	(1)	X	Insurance		(1)	X	Ins	urance	
	(2)		Code section 412(e)(3) insurance contracts		(2)		Co	de section 412(e)(3) insurance contracts	
	(3)		Trust		(3)		Tru	ust	
	(4)	X	General assets of the sponsor		(4)	X	Ge	neral assets of the sponsor	
10	10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)								
а	Pensio	on Sci	hedules	b General Schedules					
	(1)		R (Retirement Plan Information)		(1)			H (Financial Information)	
	(2)		MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	Π		I (Financial Information – Small Plan)	
			Purchase Plan Actuarial Information) - signed by the plan		(3)	X	6	A (Insurance Information)	
			actuary		(4)	X		C (Service Provider Information)	
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)			D (DFE/Participating Plan Information)	
			Information) - signed by the plan actuary		(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	Α	Insuran	ce Informatio	n			
(Form 5500)	MO				OMB No. 1210-0110	
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 a pursuant to E 	are required to provide t RISA section 103(a)(2)		tion	This Fo	rm is Open to Public Inspection
For calendar plan year 20	14 or fiscal plar	n year beginning 01/01/2014		and er	nding 12	2/31/2014	1
A Name of plan THE TERTELING CO., IN	C. GROUP BE	NEFIT PLAN			e-digit number (P	N) 🕨	501
C Plan sponsor's name a THE TERTELING CO., IN		e 2a of Form 5500		D Emplo 82-01	•	cation Number	(EIN)
		ing Insurance Contract (Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		TH AMERICA					
	(c) NAIC	(d) Contract or (e) Approximate number of Policy or contract				contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
23-1503749	65498	ABL645510	862		01/01/20)14	01/01/2015
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total	amount of com	missions paid		(b) T	otal amount	of fees paid	
		23					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
MERCER HEALTH & BE			or other person to who PAYSPHERE CIR AGO, IL 60674	m commiss	sions or fees	s were paid	
(b) Amount of sales a	nd base	Fee	s and other commissio	ns paid			_
commissions pa	id	(c) Amount		(d) Purpos	е		(e) Organization code
		23 St	JPPLEMENTAL COMM	IISSIONS			3
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	sions or fees	s were paid	1
(h) Am aunt - (ad bace	Fee	s and other commissio	ns paid			
(b) Amount of sales an commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code

For Paperwork Reduction Act Notice	e 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	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization 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	- 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					

	Schedule A (Form 5500) 2014		Pa	ige 4			
Part 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	proup of employees of the sourposes if such contracts	are experience	ce-rated as a unit. Whe	ere contracts		
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 unemp	oloyment h	Prescription drug	
i	Stop loss (large deductible)	j 🗍 HMO contract	k 🗌	PPO contract	I	I Indemnity contract	
m	X Other (specify) ACCIDENTAL DEATH		L_	2			
9 Expe	erience-rated contracts:						
a	Premiums: (1) Amount received		9a(1)		0		
	(2) Increase (decrease) in amount due but unpa	id	9a(2)				
	(3) Increase (decrease) in unearned premium re	serve	9a(3)				
	(4) Earned ((1) + (2) - (3))				9a(4)		0
b	Benefit charges (1) Claims paid		9b(1)		0		
	(2) Increase (decrease) in claim reserves		9b(2)				
	(3) Incurred claims (add (1) and (2))				9b(3)		0
	(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		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. (Thes	e amounts were 🗌 paid ir	n cash, or	credited.)	9c(2)		
d	Status of policyholder reserves at end of year: (9d(1)		
	(2) Claim reserves				9d(2)		
	(3) Other reserves				9d(3)		
					· · ·		

	е	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)				
10	0 Nonexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carrier				
	b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or				

D	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	10b	
Sp	pecify nature of costs		

9e

10a

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	Α	Insurance Information			OMB No. 1210-0110			
(Form 5500		.		101 (1)				
Department of the Treasury This schedule is required to be filed under section 104 of the Internal Revenue Service Employee Retirement Income Security Act of 1974 (ERISA).				2014				
Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.								
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		tion	This Fo	orm is Open to Public Inspection	
For calendar plan year 20	14 or fiscal plai	n year beginning 01/01/2014		and er	nding 12	/31/2014	1	
A Name of plan THE TERTELING CO., IN	C. GROUP BE	NEFIT PLAN			e-digit number (Pl	N) 🕨	501	
C Plan sponsor's name a THE TERTELING CO., IN		e 2a of Form 5500		D Emplo 82-01		ation Number	r (EIN)	
		ing Insurance Contract (Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca		TH AMERICA						
(b) EIN (c) NAIC code		(d) Contract or	(e) Approximate number of persons covered at end of policy or contract year		ber of F		contract year	
		identification number			(f)	From	(g) To	
23-1503749	65498	OK967209	862 01/01/2		01/01/20	14	01/01/2015	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in	
(a) Total a	amount of com	missions paid		(b) T	otal amount	of fees paid		
		110					1188	
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all	persons).				
MERCER HEALTH & BE			or other person to who PAYSPHERE CIR AGO, IL 60674	m commiss	sions or fees	were paid		
(b) Amount of sales ar			ees and other commissions paid				_	
commissions par	id 1188	(c) Amount	JPPLEMENTAL COMM	(d) Purpos	e		(e) Organization code	
	1100	110 30		10010110			5	
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
		Faa	s and other commission	ns naid				
(b) Amount of sales ar commissions pai	(c) Amount	(d) Purpose			(e) Organization code			

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	(e) Organization code		
commissions paid	(c) Amount	(d) Purpose			
(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					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	Contracts 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					

Ρ	aq	е	4

Part III	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. Wh	ere contract	
8 Benef	it and contract type (check all applicable boxes))				
a 🗌	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance
е	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unem	ployment	h Prescription drug
i 🗍	Stop loss (large deductible)	j 🗍 HMO contract	k	PPO contract		I Indemnity contract
m 🛛		-	L	7		
··· <u>^</u>						
9 Experi	ience-rated contracts:					
a Pr	remiums: (1) Amount received		9a(1)		7917	
(2	2) Increase (decrease) in amount due but unpai	d	9a(2)			1
(3	3) Increase (decrease) in unearned premium re	serve	9a(3)			1
(4	4) Earned ((1) + (2) - (3))				9a(4)	7917
b E	Benefit charges (1) Claims paid		9b(1)			
(2	2) Increase (decrease) in claim reserves		9b(2)			7
(3	3) Incurred claims (add (1) and (2))				9b(3)	
(4	4) Claims charged				9b(4)	
CF	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		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	e amounts were 🗌 paid ir	n cash, or	credited.)	9c(2)	
	Status of policyholder reserves at end of year: (7					
	2) Claim reserves	, ,			9d(2)	
```	3) Other reserves				9d(3)	
e	Dividends or retroactive rate refunds due. (Do r	ot include amount entered	d in line <b>9c(2</b> )	).)	9e	
	experience-rated contracts:			,		
	Fotal premiums or subscription charges paid to	carrier			10a	
b li	f the carrier, service, or other organization incur etention of the contract or policy, other than rep	red any specific costs in c	connection wit	th the acquisition or	10b	

Specify nature of costs 🕨

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

SCHEDULE	CHEDULE A Insurance Information				OMB No. 1210-0110		
,	(Form 5500)						
Department of the Treasu Internal Revenue Servic		This schedule is required Employee Retirement In					2014
Department of Labor Employee Benefits Security Adm	ninistration	File as an a	attachment to Form 55	00.			
Pension Benefit Guaranty Cor	poration	<ul> <li>Insurance companies a pursuant to E</li> </ul>	are required to provide t ERISA section 103(a)(2)		tion	This Fo	orm is Open to Public Inspection
For calendar plan year 201	4 or fiscal plar	a year beginning 01/01/2014		and er	nding 12	/31/2014	
A Name of plan THE TERTELING CO., INC	C. GROUP BE	NEFIT PLAN			e-digit number (Pl	N) 🕨	501
C Plan sponsor's name as THE TERTELING CO., INC		e 2a of Form 5500		D Emplo 82-018	-	cation Number	r (EIN)
		ing Insurance Contract					
1 Coverage Information:							
(a) Name of insurance car LIFE INSURANCE COMP		TH AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or	contract year
<b>(b)</b> EIN	code	identification number	er persons covered at en policy or contract ye				<b>(g)</b> To
23-1503749	65498	FLX965626	86	62	01/01/20	)14	01/01/2015
2 Insurance fee and comm descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
<b>(a)</b> Total a	mount of comr	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
		497					2782
3 Persons receiving comm	nissions and fe	ees. (Complete as many entries	as needed to report all	persons).			
MERCER HEALTH & BEN	()		or other person to who PAYSPHERE CIR AGO, IL 60674	m commiss	ions or fees	were paid	
(b) Amount of sales and	d base		es and other commission	ns paid			_
commissions paid		(c) Amount		(d) Purpos	е		(e) Organization code
2782 497 5			SUPPLEMENTAL COMMISSIONS			3	
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
		For	s and other commission	ns naid			
(b) Amount of sales and base commissions paid     Fees and other commissions paid       (c) Amount     (d) Purpose					(e) Organization code		

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						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			<b>6c</b>	
	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			. <b>7b</b>	
	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	

Pa	art III	If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts of	oup of employees of the surposes if such contracts	are experienc	ce-rated as a unit. Wh	nere contrac		
8	Bene	fit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		<b>d</b> X Life insurance	
	е	Temporary disability (accident and sickness)	<b>f</b> Long-term disabilit	y <b>g</b>	Supplemental unem	ployment	<b>h</b> Prescription drug	
	iΓ	Stop loss (large deductible)	j 🗍 HMO contract		PPO contract		I Indemnity contract	
	m [	Other (specify)			-			
9	Expe	rience-rated contracts:						
	<b>a</b> F	Premiums: (1) Amount received		9a(1)		35644	<u> </u>	
	(	(2) Increase (decrease) in amount due but unpaid	۶	9a(2)				
		(3) Increase (decrease) in unearned premium res	erve	9a(3)				
		(4) Earned ( <b>(1) + (2) - (3)</b> )				. 9a(4)		35644
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				. 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				. 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	benefits 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	l in line 9c(2)	.)	. 9e		
10		nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			. 10a		
		If the carrier, service, or other organization incur						
		retention of the contract or policy, other than repo				. 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.			

SCHEDULE	Α	Insuran	ce Informatio	n			1P. No. 1210.0110
(Form 5500	))					ON	/IB No. 1210-0110
	Department of the Treasury Internal Revenue Service 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 a	attachment to Form 55	00.			
Pension Benefit Guaranty Co	prporation	Insurance companies pursuant to l	are required to provide t ERISA section 103(a)(2)		ion	This For	rm is Open to Public Inspection
For calendar plan year 20	14 or fiscal pla	•		and en	ding 12	/31/2014	
A Name of plan THE TERTELING CO., IN	IC. GROUP BE	ENEFIT PLAN		B Thre- plan	e-digit number (Pl	N) 🕨	501
C Plan sponsor's name a THE TERTELING CO., IN		ne 2a of Form 5500		D Emplo 82-018		ation Number	(EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
LIFE INSURANCE COM	PANY OF NOF	RTH AMERICA					
		(d) Contract or	(e) Approximate nu	umber of		Policy or c	contract year
<b>(b)</b> EIN	(c) NAIC code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
23-1503749	65498	FLX965631	65	659		14	01/01/2015
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	tal commissions paid. L	ist in line 3	the agents,	brokers, and c	other persons in
<b>(a)</b> Total a	amount of com	missions paid		<b>(b)</b> To	otal amount	of fees paid	
		1455					15633
<b>3</b> Persons receiving com	missions and f	fees. (Complete as many entries	as needed to report all	persons).			
	1.7	and address of the agent, broker,		m commiss	ions or fees	were paid	
MERCER HEALTH & BE	NEFII5		PAYSPHERE CIR AGO, IL 60674				
(b) Amount of sales ar			es and other commission				_
commissions pa		(c) Amount		(d) Purpos	Э		(e) Organization code
	15633	1455 5	UPPLEMENTAL COMM	115510115			3
	(a) Name a	and address of the agent, broker.	, or other person to who	m commiss	ions or fees	were paid	
			,				
		Fei	es and other commissio	ns paid			

(b) Amount of sales and base	F					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
For Paparwork Poduction Act Natics and OMP Control Numbers, see 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) Nan	ne and address of the agent, broke	, 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	
	(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 commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code

Page 3

Pa	art I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contra	cts with each carrier ma	v 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			<b>6c</b>	
	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			. <b>7b</b>	
	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	
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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 were same group of same gro	oup of employees of the s rposes if such contracts a	are experien	ce-rated as a unit. Wh	ere contrac	
8 Benefit and contract type (check all applicable boxes)					
<b>a</b> Health (other than dental or vision)	<b>b</b> Dental	с	Vision		d X Life insurance
<b>e</b> Temporary disability (accident and sickness)	f Long-term disabilit	ty <b>q</b>	Supplemental unemp	oloyment	<b>h</b> Prescription drug
	i HMO contract		PPO contract		I Indemnity contract
	-	ĸ			
m X Other (specify) ►SUPPLEMENTAL LIFE INSU	RANCE				
<b>9</b> Experience-rated contracts:					
a Premiums: (1) Amount received	I	9a(1)		104222	
(2) Increase (decrease) in amount due but unpaid				104222	-
(3) Increase (decrease) in unearned premium rese					-
(4) Earned ((1) + (2) - (3))				9a(4)	104222
<b>b</b> Benefit charges (1) Claims paid					
(2) Increase (decrease) in claim reserves		9b(2)			1
(3) Incurred claims (add (1) and (2))				9b(3)	
(4) Claims charged				9b(4)	
<b>C</b> Remainder of premium: (1) Retention charges (or	an accrual basis)		ſ		
(A) Commissions					_
(B) Administrative service or other fees					_
(C) Other specific acquisition costs		9c(1)(C)			4
(D) Other expenses		9c(1)(D)			-
(E) Taxes					-
(F) Charges for risks or other contingencies					-
(G) Other retention charges (H) Total retention	L			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These	_				
				\ /	
<ul> <li>d Status of policyholder reserves at end of year: (1)</li> <li>(2) Claim reserves</li> </ul>				9d(1) 9d(2)	-
(2) Claim reserves				9d(2) 9d(3)	
<ul> <li>e Dividends or retroactive rate refunds due. (Do no</li> </ul>				9e	
10 Nonexperience-rated contracts:			,,		
a Total premiums or subscription charges paid to ca	arrier			10a	
<b>b</b> If the carrier, service, or other organization incurre					
retention of the contract or policy, other than repo				10b	

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
<b>12</b> If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuran	ce Informatio	n			IP No. 1210 0440
(Form 5500	)					ON	1B No. 1210-0110
Department of the Treas Internal Revenue Servi		This schedule is required Employee Retirement In					2014
Department of Labor Employee Benefits Security Adr		<ul> <li>File as an attachment to Form 5500.</li> </ul>					
Pension Benefit Guaranty Col		Insurance companies a pursuant to E	are required to provide t ERISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
For calendar plan year 201	14 or fiscal plar	•		and en	ding 12	/31/2014	
A Name of plan     B     Three-digit       THE TERTELING CO., INC. GROUP BENEFIT PLAN     Plan number (PN)			N) 🕨	501			
C Plan sponsor's name a THE TERTELING CO., INC		e 2a of Form 5500		D Emplo 82-018	-	ation Number	(EIN)
		ning Insurance Contract					
1 Coverage Information:							
(a) Name of insurance car	rrier						
LIFE INSURANCE COMF	PANY OF NOR						
		_	(e) Approximate nu	umber of		Policy or c	ontract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of		From	(g) To	
23-1503749	65498	FLK960760	862 01/01/2014		14	01/01/2015	
2 Insurance fee and comr descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents,	brokers, and c	other persons in
0	mount of com	missions paid		<b>(b)</b> To	otal amount	of fees paid	
		1213					4881
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		and address of the agent, broker,		m commiss	ions or fees	were paid	
MERCER HEALTH & BEI	NEFIIS		PAYSPHERE CIR AGO, IL 60674				
(b) Amount of sales an		Fee	es and other commission				_
commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
	4881	1213 SI	UPPLEMENTAL COMM	IISSIONS			3
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
		For	es and other commission	no noid			1

(b) Amount of sales and base	F			
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) Nan	ne and address of the agent, broke	, 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

Pa	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			<b>6c</b>		
	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			. <b>7b</b>		
	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					

Ρ	age	4

Pa	art II							
		If more than one contract covers the same gr						
		information may be combined for reporting put the entire group of such individual contracts					s cover individual employe	es,
8	Bene	efit and contract type (check all applicable boxes)	,			•		
	аſ	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insurance	
	еГ	Temporary disability (accident and sickness)	f X Long-term disability	y g	Supplemental unemp	olovment	<b>h</b> Prescription drug	
						Joyment		
		Stop loss (large deductible)	<b>j</b> HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Expe	erience-rated contracts:						
		Premiums: (1) Amount received		9a(1)		88122	1	
		(2) Increase (decrease) in amount due but unpaid	J				1	
		(3) Increase (decrease) in unearned premium res		9a(3)			1	
		(4) Earned ((1) + (2) - (3))				9a(4)	8	8122
	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 (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		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)		1		
		(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 t	penefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	ot include amount entered	in line 9c(2)	.)	9e		
10	) No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			10a		
	b	If the carrier, service, or other organization incurr						
		retention of the contract or policy, other than repe	orted in Part I, line 2 above	e, report amo	ount	10b		

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did t	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
<b>12</b> If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuran	ce Informatio	n		0	MB No. 1210-0110
(Form 5500)	,						
Department of the Treas		This schedule is required Employee Retirement Ind					2014
Department of Labor Employee Benefits Security Adm		File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty Con	rporation	<ul> <li>Insurance companies a pursuant to E</li> </ul>	are required to provide t RISA section 103(a)(2)		tion	This Fo	orm is Open to Public Inspection
For calendar plan year 201	14 or fiscal plar	n year beginning 01/01/2014		and er	nding 12	2/31/2014	1
A Name of plan THE TERTELING CO., INC	C. GROUP BE	NEFIT PLAN			e-digit number (Pl	N) 🕨	501
C Plan sponsor's name a THE TERTELING CO., INC		e 2a of Form 5500		D Emplo 82-018	-	cation Numbe	r (EIN)
		ing Insurance Contract ( Individual contracts grouped as					
<b>1</b> Coverage Information:							
(a) Name of insurance car LIFE INSURANCE COMP		TH AMERICA					
(c) NAIC (d) Contract or (e) Approximate number of Policy or co				contract year			
<b>(b)</b> EIN	(c) NAIC code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
23-1503749	65498	OK967215	52	22	01/01/20	)13	12/31/2013
2 Insurance fee and comr descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount	of fees paid	
		1539					
3 Persons receiving comr	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,	•	m commiss	sions or fees	were paid	
MERCER HEALTH & BEI	NEFIIS		PAYSPHERE CIR AGO, IL 60674				
(b) Amount of sales an	d base	Fee	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
	1539	140 St	JPPLEMENTAL COMM	IISSIONS			3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	sions or fees	were paid	
		Fee	es and other commission	ns paid			
(b) Amount of sales an commissions pair		(c) Amount		(d) Purpos	e		(e) Organization code

For Paperwork Reduction Act Notice	e 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

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		(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 indivi	v 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			<b>6c</b>	
	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			. <b>7b</b>	
	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				

Ρ	aq	е	4

Par	t III	Welfare Benefit Contract Informat If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the urposes if such contracts	are experience	ce-rated as a unit. Wh	ere contract			
<b>8</b> E	Benefit a	and contract type (check all applicable boxes)							
á	a    Health (other than dental or vision)    b    Dental    c    Vision    d    Life insurance								
e	е 🗍 т	emporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Supplemental unemp	ployment	h Prescription drug		
i	iΠs	Stop loss (large deductible)	j HMO contract	· · · ·	PPO contract		I Indemnity contract		
		Dther (specify) SUPPLEMENTAL ACCIDEN			]				
<b>9</b> E	xperier	nce-rated contracts:							
	•	miums: (1) Amount received		9a(1)		10261	-		
	(2)	Increase (decrease) in amount due but unpai	d				1		
	• • •	Increase (decrease) in unearned premium res					1		
	(4)	Earned ((1) + (2) - (3))				9a(4)	10261		
	<b>b</b> Be	nefit 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)			
	<b>c</b> Re	mainder 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.							
		(G) Other retention charges		9c(1)(G)		T			
		(H) Total retention				9c(1)(H)			
	(2)	Dividends or retroactive rate refunds. (These	e amounts were 🔤 paid ir	n cash, or	credited.)	9c(2)			
	<b>d</b> Sta	atus of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	r retirement	9d(1)			
	(2)	Claim reserves				9d(2)			
	(3)	(3) Other reserves							
	e Div	vidends or retroactive rate refunds due. (Do n	ot include amount entered	d in line <b>9c(2)</b>	).)	9e			
10	Nonex	perience-rated contracts:							
i	a Tot	tal premiums or subscription charges paid to o	carrier			10a			
		he carrier, service, or other organization incur	, i						
	ret	ention of the contract or policy, other than rep	10b						

Specify nature of costs 🕨

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

(Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation or calendar plan year 2014 or fiscal plan Name of plan HE TERTELING CO., INC. GROUP BE		er section 104 of the Employee Act of 1974 (ERISA). <b>t to Form 5500.</b>	This 1	2014 Form is Open to Public Inspection.
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation or calendar plan year 2014 or fiscal plan Name of plan HE TERTELING CO., INC. GROUP BE	Retirement Income Security A File as an attachmen n year beginning 01/01/2014	Act of 1974 (ERISA). <b>t to Form 5500.</b> and ending 12/31 <b>B</b> Three-digit		Form is Open to Public
Employee Benefits Security Administration Pension Benefit Guaranty Corporation or calendar plan year 2014 or fiscal plan Name of plan HE TERTELING CO., INC. GROUP BE	n year beginning 01/01/2014	and ending 12/31 B Three-digit		•
or calendar plan year 2014 or fiscal plan Name of plan HE TERTELING CO., INC. GROUP BE		B Three-digit	/2014	
Name of plan HE TERTELING CO., INC. GROUP BE		B Three-digit	/2014	
HE TERTELING CO., INC. GROUP BE	ENEFIT PLAN	-		
Plan sponsor's name as shown on line			•	501
HE TERTELING CO., INC.	D Employer Identification Number (EIN) 82-0180520			
Part I Service Provider Infor	mation (see instructions)			
Information on Persons Rec Check "Yes" or "No" to indicate whether indirect compensation for which the pla If you answered line 1a "Yes," enter t	relude that person when completing the remains reiving Only Eligible Indirect Com er you are excluding a person from the rema an received the required disclosures (see ins the name and EIN or address of each person sation. Complete as many entries as needed	pensation inder of this Part because they rece structions for definitions and conditio n providing the required disclosures	ns)	Yes 🛛 N
	ne and EIN or address of person who provide		ct compens	ation
(b) Enter nar	ne and EIN or address of person who provid	ed you disclosure on eligible indirec	t compensa	ation
(b) Enter nor	ne and EIN or address of person who provide	ad you disclosures on aligible indires	tompore	ation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

Page <b>3 -</b> 1
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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

CIGNA BEHAVIORAL HEALTH INC.

### 41-1648670

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	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	Did the service provider give you a formula instead of an amount or
	CONTRACTED TO ADMIN EAP	20683	Yes 🗌 No 🔀	Yes 🗌 No 🔀	0	Yes 🗙 No 🗌
		(	a) Enter name and EIN or	address (see instructions)		

(b)	(c)	(d)	(e)	(f)	(g)	(h)				
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect	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	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)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	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	
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗍

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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(b)	(c)	(d)	(e)	(f)	(g)	(h)				
Service Code(s)	Relationship to employer, employee	Enter direct	Did service provider receive indirect	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	Did the service provider give you a formula instead of an amount or				
			Yes 🗌 No 🗍	Yes 🗌 No 🗌		Yes No				
	(a) Enter name and EIN or address (see instructions)									

(b)	(c)	(d)	(e)	(f)	(g)	(h)		
Service	Relationship to	Enter direct	Did service provider	Did indirect compensation	Enter total indirect	Did the service		
Code(s)	employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	receive indirect compensation? (sources other than plan or plan sponsor)	include eligible indirect compensation, for which the plan received the required disclosures?	compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0			
			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	by the plan. If none,	(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	formula instead of an amount or estimated amount?
			Yes No	Yes No	(t). It none, enter -0	Yes No

# Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
		compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect c	ompensation including any
	formula used to determine t	the service provider's eligibility
		ne indirect compensation.
(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	(e) Describe the indirect conformula used to determine to	ompensation, including any the service provider's eligibility
		e indirect compensation.
(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	(e) Describe the indirect c	ompensation, including any
	formula used to determine t for or the amount of th	the service provider's eligibility ne indirect compensation.

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Pa	Part II Service Providers Who Fail or Refuse to Provide Information					
4	4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.					
(a) Enter name and EIN or address of service provider (see instructions)		(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
	<b>(a)</b> En	ter 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		
	<b>(a)</b> En	ter 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		
	<b>(a)</b> En	ter 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		
	<b>(a)</b> En	ter 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		
	<b>(a)</b> En	ter 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		

Part III		Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)				
а	Name		<b>b</b> EIN:			
C Position:						
d Address:		;s:	e Telephone:			
Explanation:						
Ex	planatio	 1:				

а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	e Telephone:
-		

Explanation:

а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	e Telephone:

Explanation: