Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2014

This Form is Open to Public Inspection

Part I		entification Information					
For calen	dar plan year 2014 or fisc	2015					
A This re	eturn/report is for:	a multiemployer plan;		e-employer plan (Filers checking this box must attach a list of thing employer information in accordance with the form instructions); or			
		x a single-employer plan;					
B This re	eturn/report is:	the first return/report;	the final retu	ırn/report;			
	, . op 611 .6.	an amended return/report;	a short plan	year return/report (less than 12	2 month	s).	
C If the	olan is a collectively-barga	ained plan, check here				•	
D Check	box if filing under:	Form 5558;	automatic ex	xtension;	the Di	FVC program;	
	•	special extension (enter description	nn)	_			
Part II	Basic Plan Info	rmation—enter all requested information	ation				
1a Name					1b	Three-digit plan	501
SELLEN	CONSTRUCTION COMP	ANY EMPLOYEE HEALTH PLAN				number (PN) ▶	
					1c	Effective date of p 03/01/1997	an
	sponsor's name and addr CONSTRUCTION COMP	ess; include room or suite number (em	ployer, if for a single	e-employer plan)	2b	Employer Identifica Number (EIN) 91-0592890	ation
PO BOX		227 WES	TLAKE AVENUE N		2c Plan Sponsor's telephon number 206-682-7770		•
SEATTLE	E, WA 98109-0970	SEATTLE	E, WA 98109		2d Business code (see instructions) 236200		e
Caution:	A penalty for the late or	incomplete filing of this return/repo	rt will be assessed	Lunless reasonable cause is	establis	shed	
Under pe	nalties of perjury and other	er penalties set forth in the instructions, ell as the electronic version of this return	I declare that I have	e examined this return/report, in	ncluding	accompanying sche	
	•				<u>, </u>		<u> </u>
SIGN	Filed with authorized/valid	electronic signature.	09/17/2015	KATHERINE SEEBER			
HERE	Signature of plan admir		Date				
	Signature or plan autili	iistrator	Date	Enter name or muividual sig	Jilliy as	ng as plan administrator	
SIGN HERE	Filed with authorized/valid	electronic signature.	09/17/2015	KATHERINE SEEBER			
	Signature of employer/	plan sponsor	Date	Enter name of individual sig	ning as	employer or plan sp	onsor
SIGN							
HERE	Signature of DFE		Date	Enter name of individual sig	ning as	DFF	
Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional) Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional)						telephone number	
				(op	tional)		

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3a	Plan administrator's name and address XSame as Plan Sponsor	3b Administrator's EIN			
		3c Admir	nistrator's telephone per		
4	If the name and/or EIN of the plan sponsor has changed since the last return/r EIN and the plan number from the last return/report:	report filed for this	plan, enter the name,	4b EIN	
а	Sponsor's name			4c PN	
5	Total number of participants at the beginning of the plan year			5	181
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d).	(welfare plans cor	nplete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year			6a(1)	181
a(2) Total number of active participants at the end of the plan year			6a(2)	191
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	191
е	Deceased participants whose beneficiaries are receiving or are entitled to receive	eive benefits		6e	
f	Total. Add lines 6d and 6e			6f	
g	Number of participants with account balances as of the end of the plan year (complete this item)			6g	
h	Number of participants that terminated employment during the plan year with a less than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only m	nultiemployer plan	s complete this item)	7	
b	If the plan provides pension benefits, enter the applicable pension feature code. If the plan provides welfare benefits, enter the applicable welfare feature code. 4A 4D 4E 4Q	es from the List of	Plan Characteristics Codes	in the ins	
9a	Plan funding arrangement (check all that apply) (1) X Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) General assets of the sponsor	9b Plan benefit (1) (2) (3) (4)	arrangement (check all that Insurance Code section 412(e)(3) in Trust General assets of the sp	nsurance (contracts
10	Check all applicable boxes in 10a and 10b to indicate which schedules are atta		e indicated, enter the numb	er attache	d. (See instructions)
а	Pension Schedules	b General Sc	hedules		
	(1) R (Retirement Plan Information)	(1)	H (Financial Inform	nation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) (3) (4)	I (Financial Information A) A (Insurance Information C) C (Service Provide	mation) r Informati	on)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) (6)	D (DFE/Participating (Financial Transa	-	

Form 5500 (2014) Page **3**

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)						
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)							
If "Yes" is checke	If "Yes" is checked, complete lines 11b and 11c.						
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)							
11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)							
Receipt Confirmation Code							

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2014

This Form is Open to Public

pursuant to ERISA section 103(a)(2).						inspection		
For calendar plan year 20°	14 or fiscal pla	n year beginning 03/01/2014	1	and en	ding 02	2/28/2015		
A Name of plan SELLEN CONSTRUCTION	N COMPANY I	EMPLOYEE HEALTH PLAN		B Three plan	e-digit number (P	PN) •	501	
C Plan sponsor's name a SELLEN CONSTRUCTION		e 2a of Form 5500		D Employ 91-059		cation Number (l	EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca	rrier							
DELTA DENTAL OF WAS	SHINGTON		1	Ţ				
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			Policy or co	ntract year	
(b) LIN	code	identification number	policy or contract		(f) From	(g) To	
91-0621480	47341	9360	4:	437 03/01/2014		014	02/28/2015	
2 Insurance fee and complete descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents	, brokers, and ot	her persons in	
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid							
		0					0	
3 Persons receiving com		ees. (Complete as many entrie						
	(a) Name a	and address of the agent, broke	er, or other person to who	m commissi	ions or fee	s were paid		
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid				
commissions pai		(c) Amount	(d) Purpose			(e) Organization code		
	(a) Name a	and address of the agent, broke	er, or other person to who	m commissi	ions or fee	s were paid		
		.	,					
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid				
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code	

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

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	be treated	d as a unit for purposes of		
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
-		racts 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 corretention of the contract or policy, enter amount.	nnection with th	ne acquisition or	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan, che	eck here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in sep	arate accounts)	·	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatior	n guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

Pa	age 4		
experience	ver(s) or members of the same er ce-rated as a unit. Where contra unit for purposes of this report.		
c g k	Vision Supplemental unemployment PPO contract	d [h [l []	Life insurance Prescription drug Indemnity contract
a(1)	20267	1	
a(2)			

		information may be combined for reporting put the entire group of such individual contracts with the entire group of the entire group of such individual contracts with the entire group of the entire group	urposes if such contracts a	are experienc	e-rated as a unit. Whe	ere contract		
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b X Dental	С	Vision		d Life insuran	nce
	e 🗏	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unemp	oloyment	h Prescription	n drug
	ιĒ	Stop loss (large deductible)	j HMO contract	k -		-	I Indemnity c	contract
	m	Other (specify)	, 🗆e seimae		,		- 🗀asy s	
9	Expe	rience-rated contracts:						
	a P	Premiums: (1) Amount received		9a(1)		202671		
	((2) Increase (decrease) in amount due but unpaid	t	9a(2)				
	((3) Increase (decrease) in unearned premium res	serve	9a(3)				
	((4) Earned ((1) + (2) - (3))				9a(4)		202671
	b	Benefit charges (1) Claims paid	<u></u>	9b(1)		140166		
	((2) Increase (decrease) in claim reserves		9b(2)		1000		
	((3) Incurred claims (add (1) and (2))				9b(3)		141166
	((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)		20267		
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention	<u></u>	<u></u>		9c(1)(H)		20267
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide b	penefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		5000
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2)	.)	9e		
10	Nor	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			10a		
		If the carrier, service, or other organization incurretention of the contract or policy, other than repo	, ,			10b		
	Spe	ecify nature of costs						

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

Schedule A (Form 5500) 2014

Part III Welfare Benefit Contract Information

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

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2014

This Form is Open to Public

r ension benefit dualarity oc	проганоп	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					Inspection
For calendar plan year 20							
A Name of plan		EMPLOYEE HEALTH PLAN			e-digit number (PN	l) >	501
C Plan sponsor's name a SELLEN CONSTRUCTIO				D Emplo		ation Number	(EIN)
		ning Insurance Contract. Individual contracts grouped a					
(a) Name of insurance ca		NC.					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate ni persons covered a policy or contract	at end of	(f)	Policy or c	ontract year (g) To
52-2135463	54199	SELL0		78	03/01/201	14	02/28/2015
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, I	brokers, and c	ther persons in
		nmissions paid		(b) To	otal amount o	of fees paid	
3 D		0					0
3 Persons receiving com		fees. (Complete as many entried and address of the agent, broke			. ,		
(b) Amount of sales ar		•	ees and other commissio		10113 01 1003	were paid	
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
	(1)	J					
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

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

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	ridual contract	s with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		tracts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	70/4			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2) 7e(3)			
		(3) Transferred to separate account	7e(3) 7e(4)			
		(4) Other (specify below)	16(4)			
		•				
		(5) Total deductions.			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

Schedule A (Form 5500) 2014	Page 4
	es of the same employer(s) or members of the same employee organizations(s), the contracts are experience-rated as a unit. Where contracts cover individual employee may be treated as a unit for purposes of this report.
efit and contract type (check all applicable boxes)	
Health (other than dental or vision) b Dental	c
Temporary disability (accident and sickness) f Long-terr	m disability g Supplemental unemployment h Prescription drug
Stop loss (large deductible) j HMO con	ntract k PPO contract I Indemnity contract
X Other (specify) ▶EMPLOYEE ASSISTANCE PLAN	
_	
erience-rated contracts:	
Premiums: (1) Amount received	9a(1)
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	
Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	
(3) Incurred claims (add (1) and (2))	
(4) Claims charged	
Remainder of premium: (1) Retention charges (on an accrual bas	
(A) Commissions	

9c(1)(H)

9c(2)

9d(1)

9d(2)

9d(3)

9e

10a

10b

3012

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

10 Nonexperience-rated contracts:

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

Experience-rated contracts:

m X Other (specify) ▶EMPLOYEE ASSISTANCE PLAN

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

Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions (B) Administrative service or other fees.....

(C) Other specific acquisition costs (D) Other expenses.....

(E) Taxes.....

(F) Charges for risks or other contingencies.....

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

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

(2) Claim reserves

(3) Other reserves.....

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

Total premiums or subscription charges paid to carrier

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

Part III

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

9c(1)(B) 9c(1)(C)

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

9c(1)(F)

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

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2014

This Form is Open to Public

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).						Inspection	
For calendar plan year 20	14 or fiscal pla	an year beginning 03/01/201	4	and en	iding 02/	28/2015	
A Name of plan SELLEN CONSTRUCTION COMPANY EMPLOYEE HEALTH PLAN					e-digit number (PN	l) >	501
C Plan sponsor's name a SELLEN CONSTRUCTIO				D Emplo		ation Number	(EIN)
		ning Insurance Contrac . Individual contracts grouped a					
(a) Name of insurance ca							
(h) FIN	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
91-1467158	47055	5693100	4:	35	03/01/201	14	02/28/2015
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, I	brokers, and o	other persons in
(a) Total a	amount of con	nmissions paid		(b) To	otal amount o	of fees paid	
		0					0
3 Persons receiving com		fees. (Complete as many entrie					
		and address of the agent, broke	ees and other commissio		lons or rees	were paid	1
(b) Amount of sales ar commissions pa		(c) Amount		is paid (d) Purpose	e		(e) Organization code
		(7)		(1)	-		
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
	(4)		,			p	
(b) Amount of sales ar	nd base	<u> </u>	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

Schedule A (Form 5500) 2014 Page 2 - 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid	•		
(a) Na	line and address of the agent, broke	er, or other person to whom commissions or rees were paid			
		Fees and other commissions paid	T		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
	(0)	(5)			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(4)	and and address of the agent, protect	n, et estici person to mism commiscione et rece maio paid			
(h) American of a class and have		Fees and other commissions paid	(-) () (
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	T		1		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	ridual contract	s with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		tracts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	70/4			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2) 7e(3)			
		(3) Transferred to separate account	7e(3) 7e(4)			
		(4) Other (specify below)	16(4)			
		•				
		(5) Total deductions.			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

Page	4

Pa	art I	Welfare Benefit Contract Informat If more than one contract covers the same gi information may be combined for reporting p the entire group of such individual contracts	oup of employees of the surposes if such contracts	are experienc	e-rated as a unit. Whe	ere contract	. ,
8	Ber	nefit and contract type (check all applicable boxes)					
	а	X Health (other than dental or vision)	b Dental	c×	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	ty g	Supplemental unemp	oloyment	h X Prescription drug
	i	Stop loss (large deductible)	j HMO contract	kΧ	PPO contract		I Indemnity contract
	m	Other (specify)	_				_
9	Ехр	erience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	d	9a(2)			
		(3) Increase (decrease) in unearned premium res	serve	9a(3)			
	_	(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		. ,			
		(2) Increase (decrease) in claim reserves				21 (2)	
		(3) Incurred claims (add (1) and (2))				9b(3)	_
	_	(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (c	,	00/1\/A\			-
		(A) Commissions(B) Administrative service or other fees		9c(1)(A) 9c(1)(B)			-
		(C) Other specific acquisition costs		9c(1)(C)			-
		(D) Other expenses		0 (4)(D)			
		(E) Taxes		0 (4)(5)			-
		(F) Charges for risks or other contingencies.		0 (4)(5)			
		(G) Other retention charges		2 (1)(2)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1	_			9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2) .	.)	9e	
10	No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to o	arrier			10a	1817851
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep	, ,		•	10b	
	S	pecify nature of costs					

Par	t IV	Provision of Information			
11	Did the	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.