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

Part I	Annual Report Ide	entification Information					
For cale	ndar plan year 2014 or fisca	ll plan year beginning 05/01/2014		and ending 04/30/	2015		
A This	return/report is for:	a multiemployer plan;			-	this box must attach a list of ordance with the form instructions); or	
		X a single-employer plan;	a DFE (speci	ify)			
B This	return/report is:	the first return/report;	the final retu	rn/report;			
- 11110	otani, roport io.	an amended return/report;	a short plan	year return/report (less tha	ın 12 month	s).	
C If the	plan is a collectively bargai	ned plan, check here	_				
						_	
D Chec				the Di	FVC program;		
_		special extension (enter description	,				
Part		mation—enter all requested information	tion		1 41		ı
	ne of plan , INC. WELFARE BENEFIT	S PLAN				Three-digit plan number (PN) ▶	501
					10	Effective date of pl 01/01/1975	an
2a Plan	sponsor's name and addre	ess; include room or suite number (emp	loyer, if for a single-	employer plan)	2b	Employer Identifica	ation
UNISEA	, INC.					Number (EIN) 91-0917126	
					2c	Plan Sponsor's tele	enhone
						number	эрпопо
	E 90TH STREET ND, WA 98052	PO BOX 9 REDMONI	7019 D, WA 98073			425-881-818	
	,		,		2d Business code (see instructions) 311710		e
						011710	
Caution	• A penalty for the late or i	incomplete filing of this return/report	t will be assessed	unless reasonable caus	e is establis	shed	
		penalties set forth in the instructions, I					edules,
		l as the electronic version of this return					
SIGN	Filed with authorized/valid	electronic signature.	11/04/2015	CHRIS PLAISANCE			
HERE	Signature of plan admin	istrator	Date	Enter name of individua	Enter name of individual signing as plan administrator		
SIGN							
HERE	Signature of employer/p	lan sponsor	Date	Enter name of individua	l signing as	employer or plan sp	onsor
SIGN							
HERE Signature of DFE Date Enter name of individual signing as DFE					DFE		
Preparer	's name (including firm nam	ne, if applicable) and address (include r	oom or suite numbe	er) (optional)		telephone number	
					(optional)		
				1			

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3a	Plan administrator's name and address Same as Plan Sponsor		3b Administrator's EIN		
			3c Administrator's telephone number		
4	If the name and/or EIN of the plan sponsor has changed since the last return/rep	port filed for	this plan, enter the name,	4b EIN	
а	EIN and the plan number from the last return/report: Sponsor's name			4c PN	
5	Total number of participants at the beginning of the plan year			E	1006
6	Number of participants as of the end of the plan year unless otherwise stated (w 6a(2), 6b, 6c, and 6d).	welfare plans	s complete only lines 6a(1),	5	1026
a(*) Total number of active participants at the beginning of the plan year			6a(1)	1024
a(2	2) Total number of active participants at the end of the plan year			6a(2)	936
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	936
е	Deceased participants whose beneficiaries are receiving or are entitled to receiv	ve 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 (onl complete this item)			6g	
h	Number of participants that terminated employment during the plan year with ac less than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only mul			7	
b	If the plan provides pension benefits, enter the applicable pension feature codes If the plan provides welfare benefits, enter the applicable welfare feature codes 4A 4B 4D 4E 4G 4H 4L	from the Lis	st of Plan Characteristics Code	s in the inst	
9a	Plan funding arrangement (check all that apply) (1)	(1) (2) (3) (4)	nefit arrangement (check all the X Insurance Code section 412(e)(3) Trust X General assets of the specific arrangement (check all the	insurance o	contracts
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attack				d. (See instructions)
а	Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(1) (2)	H (Financial Inform I (Financial Inform X _5_ A (Insurance Inform	nation – Sm	nall Plan)
	Purchase Plan Actuarial Information) - signed by the plan actuary (3)				ormation)

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 checked, complete lines 11b and 11c.				
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)				
11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)				
Receipt Confirmation Code				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2014

		pursuant to I	ERISA section 103(a)(2)				
For calendar plan year 20	14 or fiscal pla	n year beginning 05/01/2014		and en	ding 04	4/30/2015	
A Name of plan UNISEA, INC. WELFARE	BENEFITS PL	AN			e-digit number (P	PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 UNISEA, INC.				D Emplo	-	cation Number (EIN)
		ing Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
OOADEE EII E	1		(a) Approximate p	umbar of		Policy or co	entract year
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a				Ĭ
(2) 2	code	identification number	policy or contrac		(f) From	(g) To
71-0505232	94358	50014118	93	36	05/01/2	014	04/30/2015
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents	, brokers, and of	her persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount	t of fees paid	
	18914						
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fee	s were paid	
GALLAGHER BENEFIT S	SERVICES, IN	C. 110 V BREI	VINNERS CIRCLE NTWOOD, TN 37027				
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose		(e) Organization code		
	14125						3
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fee	s were paid	
CONNEXION INSURANCE SOLUTIONS INC. PO BOX 34315 SEATTLE, WA 98124							
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid	·		
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
	4789						3
							l

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

Schedule A (Form 5500) 2014		Page 4		
rt III Welfare Benefit Contract Inform If more than one contract covers the same information may be combined for reporting the entire group of such individual contract	group of employees of the sai purposes if such contracts are	e experience-rated as a uni	t. Where contract	
Benefit and contract type (check all applicable boxe	s)			
a Health (other than dental or vision)	b Dental	c Vision		d X Life insurance
e Temporary disability (accident and sickness)	f X Long-term disability	g Supplemental	unemployment	h Prescription drug
i Stop loss (large deductible)	j HMO contract	k PPO contract	. ,	I Indemnity contract
	_	N _ 11 0 community		
m ☑ Other (specify) ►ACCIDENTAL DEATH AN	ID DISWEWBERWENT			
Experience-rated contracts:				
a Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unp		9a(2)		
(3) Increase (decrease) in unearned premium		9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)	
b Benefit charges (1) Claims paid		9b(1)	·	
(2) Increase (decrease) in claim reserves		9b(2)		
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges	(on an accrual basis)			
(A) Commissions	<u>.</u>	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)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

70623

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)

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

(H) Total retention.....

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

(2) Claim reserves

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

Total premiums or subscription charges paid to carrier

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

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

Part III

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

9c(1)(E)

9c(1)(F)

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

Department of the Treasury Internal Revenue Service

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Pension Benefit Guaranty Corporation

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File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2014

		pursuant to	ERISA section 103(a)(2).			•
For calendar plan year 20	14 or fiscal pla	an year beginning 05/01/2014	4 :	and ending 0	04/30/2015	
A Name of plan UNISEA, INC. WELFARE BENEFITS PLAN			В	Three-digit plan number (F	PN) ▶	501
C Plan sponsor's name a UNISEA, INC.	ne 2a of Form 5500		Employer Identif 91-0917126	ication Number (EIN)	
		ning Insurance Contrac . Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance ca		OE AMERICA				
ONOW EIL E INCONVINCI	1	OI /IIVILITIO/T	(a) Approximate number	or of	Policy or or	entract voor
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number persons covered at end	d of	Policy or co	•
(2) 2	code	identification number	policy or contract year		f) From	(g) To
01-0278678	62235	578631	66	05/01/2	2014	04/30/2015
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. List in	n line 3 the agents	s, brokers, and ot	her persons in
(a) Total a	amount of con	nmissions paid		(b) Total amour	nt of fees paid	
	9778 611					
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all pers	sons).		
	(a) Name	and address of the agent, broke	er, or other person to whom co	ommissions or fee	es were paid	
GALLAGHER BENEFIT	SERVICES, IN	NC. 777 BEI	108TH AVENUE NE, SUITE LLEVUE, WA 98004	200		
(h) Amount of color on	- d b	F	ees and other commissions pa	aid		
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpose			(e) Organization code
	9778	, ,	, ,	·		3
	(a) Name					
GALLAGHER BENEFIT S	1 /	and address of the agent, broke	or other person to whom co O PIERCE PLACE, 14TH FLC		es were paid	
ITASCA, IL 60143						
(b) Amount of sales ar	nd base	F	ees and other commissions pa	aid		
commissions paid (c) Amount			(d) F	Purpose		(e) Organization code
		611	ADDITIONAL COMPENSATION	ON		3
		I.				

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

Schedule A (Form 5500) 2014		Page 4		
I Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the same ourposes if such contracts are	experience-rated	d as a unit. Where contract	
efit and contract type (check all applicable boxes)				
Health (other than dental or vision)	b Dental	C Visio	n	d X Life insurance
Temporary disability (accident and sickness)	f Long-term disability	g Supp	lemental unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k∏ PPO	contract	I Indemnity contract
Other (specify)	_	_		_
erience-rated contracts:				
Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unpai	d	9a(2)		
(3) Increase (decrease) in unearned premium re-	serve	9a(3)		
(4) Earned ((1) + (2) - (3))	·····		9a(4)	
Benefit charges (1) Claims paid	<u></u>	b(1)		
(2) Increase (decrease) in claim reserves	Ç	b(2)		
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
Remainder of premium: (1) Retention charges (on an accrual basis)			

10b

(2) Increase (decrease) in claim reserves..... (3) Incurred claims (add (1) and (2)) (4) Claims charged Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions 9c(1)(A) (B) Administrative service or other fees..... 9c(1)(B) 9c(1)(C) (C) Other specific acquisition costs (D) Other expenses..... 9c(1)(D) 9c(1)(E) (E) Taxes..... (F) Charges for risks or other contingencies..... 9c(1)(F) 9c(1)(H) (H) Total retention..... (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)..... 9c(2)d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves..... 9d(3) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... 9e 10 Nonexperience-rated contracts: 10a Total premiums or subscription charges paid to carrier 45425

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.....

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

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

m ☐ Other (specify) ▶

Experience-rated contracts:

Specify nature of costs

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

Part III

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2014

For calendar plan year 2014 or fiscal plan year beginning 05/01/2014 and ending 04/30/2015								
A Name of plan UNISEA, INC. WELFARE	BENEFITS PL	AN	В	Three	e-digit number (PN)	501		
C Plan sponsor's name a UNISEA, INC.	s shown on lin	e 2a of Form 5500		Employ 91-091	yer Identification Numbe 7126	r (EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca	rrier							
LIFE INSURANCE COMP	PANY OF NOR	TH AMERICA						
		4.5.	(e) Approximate numbe	er of	Policy or	contract year		
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end policy or contract year	d of	(f) From	(g) To		
23-1503749	65498	OK963737	936		01/01/2014	12/31/2014		
2 Insurance fee and composite descending order of the		ation. Enter the total fees and total	al commissions paid. List in	line 3 t	he agents, brokers, and	other persons in		
	amount of com	missions naid		(b) To	tal amount of fees paid			
(a) Total t	arriount or com	1713		(6) 10	tal amount of 1000 paid	52		
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all perso	ons).				
	(a) Name a	and address of the agent, broker,	or other person to whom cor	mmissi	ons or fees were paid			
GALLAGHER BENEFIT S	SERVICES, IN	C. TWO	PIERCE PLACE, 14TH FLO CA, IL 60143	OOR				
(b) Amount of sales ar	nd hase	Fee	s and other commissions pa	aid				
commissions pai		(c) Amount	(d) Purpose			(e) Organization code		
	1713	52 O\	/ERRIDE			3		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
	. ,	<u> </u>	'		•			
Fees and other commissions paid								
(b) Amount of sales ar commissions pai		(c) Amount	'	Purpose	•	(e) Organization code		
For Panerwork Reduction	n Act Notice a	and OMB Control Numbers, see	the instructions for Form	5500				

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

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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	

		Schedule A (Form 5500) 2014		Pag	ge 4			
Pa	art II	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting p the entire group of such individual contracts of	roup of employees of the surposes if such contracts	are experienc	e-rated as a unit. Whe	ere contract		
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty \mathbf{g}	Supplemental unemp	loyment	h Prescription drug	
	ιĪ	Stop loss (large deductible)	j HMO contract	k∏	PPO contract		I Indemnity contract	
	m	Other (specify) ACCIDENTAL DEATH AND	· 🗆				"	
	[
9	Expe	rience-rated contracts:						
	a I	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		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 (c	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 \square paid in	n cash. or □ d	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				9e		_

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

10a

10b

6853

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

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....

10 Nonexperience-rated contracts:

Specify nature of costs >

¹² If the answer to line 11 is "Yes," specify the information not provided. ▶ DID NOT PROVIDE THE APPROXIMATE NUMBER OF PERSONS COVERED.

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2014 or fiscal plan year beginning

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

and ending

04/30/2015

05/01/2014

OMB No. 1210-0110

2014

A Name of plan UNISEA, INC. WELFARE BENEFITS PLAN				B Three plan	e-digit number (PN)	501	
					. ,		
C Plan sponsor's name a UNISEA, INC.	s shown on line	2a of Form 5500		D Emplo 91-091	yer Identification Number 7126	(EIN)	
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
HYATT LEGAL PLANS							
	(c) NAIC	(d) Contract or	(e) Approximate nur		Policy or c	ontract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f) From	(g) To	
34-1650967	00000	6090204	4	4	05/01/2014	04/30/2015	
2 Insurance fee and communication descending order of the		tion. Enter the total fees and tota	Il commissions paid. Lis	st in line 3	the agents, brokers, and c	ther persons in	
(a) Total a	amount of comn	•		(b) To	tal amount of fees paid		
		107				29	
3 Persons receiving com		es. (Complete as many entries a					
GALLAGHER BENEFIT S		nd address of the agent, broker, o	or other person to whom DSTH AVENUE NE, SUI		ions or fees were paid		
GALLAGILER BENEFIT C	SERVICES, INC	BELLE	EVUE, WA 98004	TL 200			
(b) Amount of sales ar	nd base	Fees	s and other commissions	s paid			
commissions pai	d	(c) Amount		(d) Purpose		(e) Organization code	
	107	12 NC	N-MONETARY COMPE	ENSATION	N	3	
	(a) Name a	nd address of the agent, broker,	or other person to whom	n commissi	ions or fees were paid		
GALLAGHER BENEFIT S	SERVICES, INC	SUITE	ARKSPUR LANDING CI : 120 SPUR, CA 94939	RCLE			
(b) Amount of sales ar	(b) Amount of sales and base Fees and other commissions paid						
commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
		17 SU	PPLEMENTAL COMPE	NSATION	I	3	
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	the instructions for Fo	orm 5500.	-		

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

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts	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		
-		ntracts 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		

Schedule A (Form 5500) 2014		Page 4			
Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting put the entire group of such individual contracts w	oup of employees of the sauroposes if such contracts are	e experience-rated as	a unit. Where contra		_
and contract type (check all applicable boxes)					
ealth (other than dental or vision)	b Dental	c Vision		d Life insurance	
emporary disability (accident and sickness)	f Long-term disability	g Suppleme	ental unemployment	h Prescription drug	
top loss (large deductible)	j HMO contract	k PPO con	tract	I Indemnity contract	
Other (specify) LEGAL	_	_		_	
nce-rated contracts:					
niums: (1) Amount received		9a(1)			
Increase (decrease) in amount due but unpaid	1	9a(2)			
Increase (decrease) in unearned premium reserve					
Earned ((1) + (2) - (3))			9a(4)		
nefit charges (1) Claims paid		9b(1)			
Increase (decrease) in claim reserves		9b(2)			

a Health (other than dental or vision) **b** Dental Temporary disability (accident and sickness) Long-term disability Stop loss (large deductible) i ☐ HMO contract m X Other (specify) ▶LEGAL Experience-rated contracts: a Premiums: (1) Amount received...... (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))..... 9b(3) (4) Claims charged 9b(4) Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions 9c(1)(A) (B) Administrative service or other fees..... 9c(1)(B) 9c(1)(C) (C) Other specific acquisition costs (D) Other expenses..... 9c(1)(D) 9c(1)(E) (E) Taxes..... (F) Charges for risks or other contingencies..... 9c(1)(F) 9c(1)(H) (H) Total retention..... (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)..... 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves..... 9d(3) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... 9e 10 Nonexperience-rated contracts: 10a Total premiums or subscription charges paid to carrier 1073 If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or 10b retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... 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	

8 Benefit and contract type (check all applicable boxes)

Part III

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

			ERISA section 103(a)(2).	mation		Inspection
For calendar plan year 20	14 or fiscal pla	an year beginning 05/01/2014	an	d ending 04/3	0/2015	
A Name of plan UNISEA, INC. WELFARE	BENEFITS PI	LAN		Three-digit plan number (PN)	•	501
C Plan sponsor's name a UNISEA, INC.	s shown on lir	ne 2a of Form 5500		mployer Identificat I-0917126	ion Number (EIN)
		ning Insurance Contract Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance ca						
NATIONAL UNION FIRE	INSURANCE	COMPANY OF PITTSBURGH,				
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number persons covered at end of		Policy or co	ontract year
(b) EIN	code	identification number	policy or contract year	(f) F	rom	(g) To
25-0687550	19445	GTP9119332N	936	05/01/2014	1	04/30/2015
2 Insurance fee and communication descending order of the		nation. Enter the total fees and to	otal commissions paid. List in lin	ne 3 the agents, br	okers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
		405				0
3 Persons receiving com		fees. (Complete as many entrie		•		
GALLAGHER BENEFIT S		and address of the agent, broke	r, or other person to whom com 108 AVENUE NE, SUITE 200	missions or fees w	ere paid	
OALLAOHEN BENEFIT (SERVICES, III	BEL	LEVUE, WA 98004			
(b) Amount of sales ar	nd hasa	Fe	ees and other commissions paid	 I		
commissions pa		(c) Amount	(d) Purpose			(e) Organization code
	405					3
	()) !			,	.,	
	(a) Name	and address of the agent, broke	r, or other person to whom com	missions or fees w	ere paid	
(b) Amount of sales ar	nd base	Fe	ees and other commissions paid	l		
commissions pa	id	(c) Amount	(d) Pu	rpose		(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.	idual contracts	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		
-		ntracts 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		

Schedule A (Form 5500) 2014		Paç	ge 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 sa urposes if such contracts ar	re experienc	e-rated as a unit. Who	ere contract	
8 Benefit and contract type (check all applicable boxes)					
a Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
e Temporary disability (accident and sickness)	f Long-term disability	g∏	Supplemental unemp	loyment	h Prescription drug
i Stop loss (large deductible)	j HMO contract			•	I Indemnity contract
	· 🗀	•.□	11 0 contract		I I I I I I I I I I I I I I I I I I I
m ☒ Other (specify) ▶BUSINESS TRAVEL ACCIE	DEN I				
9 Experience-rated contracts:					
a Premiums: (1) Amount received		9a(1)			
(2) Increase (decrease) in amount due but unpai		9a(2)			_
(3) Increase (decrease) in unearned premium re	-	9a(3)			
(4) Earned ((1) + (2) - (3))				9a(4)	
b Benefit charges (1) Claims paid				()	
(2) Increase (decrease) in claim reserves		9b(2)			
(3) Incurred claims (add (1) and (2))	_			9b(3)	
(4) Claims charged				9b(4)	
c Remainder of premium: (1) Retention 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 in c	cash, or	redited.)	9c(2)	
d Status of policyholder reserves at end of year: () Amount held to provide be	enefits after	retirement	9d(1)	
(2) Claim reserves	•			9d(2)	
(3) Other reserves				9d(3)	

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

9e

10a

10b

2700

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

a Total premiums or subscription charges paid to carrier

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....

10 Nonexperience-rated contracts:

Specify nature of costs >

¹² If the answer to line 11 is "Yes," specify the information not provided. ▶ DID NOT PROVIDE THE APPROXIMATE NUMBER OF PERSONS COVERED.

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

				Inspection	
Annual Report Ide	ntification Information				
		05/01/2014	and ending	04/30/2015	
return/report is for:	a multiemployer plan;	_			ons); or
	a single-employer plan;		5 5		
return/report is:	the first return/report;	the final retur	n/report;		
	an amended return/report;	a short plan y	ear return/report (less tha	n 12 months).	
e plan is a collectively-bargain	ned plan, check here	_			
ok box ii iiiiig diidei.	님			Dr. t.e program,	
II Racic Plan Infor			***************************************		48.00
	mation—enter an requested in	ilomation		1b Three-digit plan	
	e Benefits Plan			number (PN) ▶	501
zoda, ino. woziar				1c Effective date of pl 01/01/1975	an
	ss; include room or suite number	r (employer, if for a single-	employer plan)	2b Employer Identification Number (EIN) 91-0917126	tion
400 NE 90th Street	t			number	
		WA	98052	2d Business code (see instructions) 311710	2
dmond		WA	98073		
				is a stablished	
					dules
nts and attachments, as well	as the electronic version of this	return/report, and to the be	est of my knowledge and b	pelief, it is true, correct, and com	plete.
Mi	Alaxanee	11/4/2015	Chris F	laisance	
Signature of plan adminis	strator	Date	Enter name of individual	signing as plan administrator	
Signature of employer/pla	an sponsor	Date	Enter name of individual	signing as employer or plan sp	onsor
Signature of DFE		Date			
r's name (including firm name	e, if applicable) and address (incl	lude room or suite number	, , ,		
	endar plan year 2014 or fiscal return/report is for: return/report is: Replan is a collectively-bargain ck box if filing under: Replan Informe of plan isea, Inc. Welfard isea, Inc. 400 NE 90th Streed dmond Box 97019 dmond Replan is a collectively-bargain ck box if filing under: 400 NE 90th Streed dmond Replan is a collectively-bargain ck box if filing under: 400 NE 90th Streed dmond Replan is a collectively-bargain ck box if filing under: 400 NE 90th Streed dmond Box 97019 dmond Signature of perjury and other ents and attachments, as well Signature of plan administication contains and attachments. Signature of plan administication contains and attachments.	endar plan year 2014 or fiscal plan year beginning return/report is for: a single-employer plan; the first return/report; an amended return/report; an amended return/report; be plan is a collectively-bargained plan, check here	endar plan year 2014 or fiscal plan year beginning return/report is for: a multiemployer plan; a single-employer plan; be plan is a collectively-bargained plan, check here. ck box if filing under: participating in a short plan year beginning participating in a DFE (specific plan is a collectively-bargained plan, check here. ck box if filing under: prom 5558; psecial extension (enter description) Basic Plan Information—enter all requested information me of plan iSea, Inc. Welfare Benefits Plan n sponsor's name and address; include room or suite number (employer, if for a single-iSea, Inc. 400 NE 90th Street dmond Box 97019 dmond WA A penalty for the late or incomplete filing of this return/report will be assessed to be participated and attachments, as well as the electronic version of this return/report, and to the both signature of plan administrator Date Signature of employer/plan sponsor Date Signature of DFE Date	endar plan year 2014 or fiscal plan year beginning os/01/2014 and ending a multiple-employer plan; a single-employer plan; a single-employer plan; beginning a single-employer plan; a single-employer plan; beginning beginning a single-employer plan; beginning beginning a single-employer plan; beginning beginning beginning a single-employer information in an an animal plan, check here. ck box if filing under: Form 5558; special extension (enter description) Basic Plan Information—enter all requested information me of plan i Sea, Inc. Welfare Benefits Plan n sponsor's name and address; include room or suite number (employer, if for a single-employer plan) i Sea, Inc. 400 NE 90th Street dimond Box 97019 dmond WA 98052 benalties of perjury and other penalties set, forth in the instructions, I declare that I have examined this return/report and to the best of my knowledge and I support of the late or incomplete filing of this return/report will be assessed unless reasonable cause tenalties of perjury and other penalties set, forth in the instructions, I declare that I have examined this return/report and to the best of my knowledge and I support of the late of individual signature of plan administrator Date Enter name of individual Signature of DFE s name (including firm name, if applicable) and address (include room or suite number) (optional)	and plan year 2014 or fiscal plan year beginning 05/01/2014 and ending 04/30/2015 return/report is for:

3a	Plan administrator's name and address Same as Plan Sponsor	3b Adr	ministrator's EIN
			ministrator's telephone mber
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	4b EIN	I
а	Sponsor's name	4c PN	
5	Total number of participants at the beginning of the plan year	5	1,026
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		
a(1	1) Total number of active participants at the beginning of the plan year	6a(1)	1,024
a(2	2) Total number of active participants at the end of the plan year	6a(2)	936
b	Retired or separated participants receiving benefits	6b	0
C	Other retired or separated participants entitled to future benefits.	6c	0
d	Subtotal. Add lines 6a(2), 6b, and 6c.	6d	936
е	Deceased participants whose beneficiaries are receiving or are entitled to receive 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 (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	
b	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes 4A 4B 4D 4E 4G 4H 4L	in the in	
	Plan funding arrangement (check all that apply) (1)	t apply)	
	(2) Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) in	nsurance	contracts
	(3) Trust (3) Trust		
40	(4) X General assets of the sponsor (4) X General assets of the spo		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number	er attach	nea. (See instructions)
а	Pension Schedules (1) R (Retirement Plan Information) (2) R (Retirement Plan Information)		
	(1) R (Retirement Plan Information) (1) H (Financial Information)	ation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money (2) I (Financial Information) - signed by the plan (3) 5 A (Insurance Information)		mali Plan)
	actuary agreement (b)		tion)
	(4) C (Service Provider SB (Single-Employer Defined Benefit Plan Actuarial (5) D (DFE/Participating		- N
	Information) - signed by the plan actuary (6) G (Financial Transa		

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.)				
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.)				

Form 5500 (2014)

Receipt Confirmation Code_____

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