### 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

	_					inspection		
Part I		entification Information						
For cale	ndar plan year 2014 or fisca	al plan year beginning 07/01/2014		and ending 06/30/20	015			
A This	return/report is for:	a multiemployer plan;		a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or				
		a single-employer plan;	a DFE (spec	ify)				
<b>B</b> This	eturn/report is:	the first return/report;	the final retu	rn/report;				
		an amended return/report;	a short plan	year return/report (less than	12 month	s).		
C If the		<b>▶</b> □						
	k box if filing under:	Form 5558;	tension;	_	- ⊔ FVC program;			
D Chec	k box ii iiiiiig dildei.	special extension (enter descript		,	L 21	roprogram,		
Part	II Rasic Plan Info	rmation—enter all requested inform	•					
	ne of plan	mation—enter all requested infor	nation		1b	Three-digit plan	504	
	•	WELFARE BENEFIT PLAN				number (PN) ▶	501	
					1c	1c Effective date of plan 06/01/2006		
	sponsor's name and addre	ess; include room or suite number (er	mployer, if for a single	-employer plan)	2b	Employer Identifica Number (EIN) 91-0449170	ation	
P. O. BC			UTH 2ND STREET		2c	2c Plan Sponsor's telephone number 509-649-2211		
ROSLY	I, WA 98941	ROSLYI	N, WA 98941		2d	2d Business code (see instructions) 517000		
Caution	: A penalty for the late or	incomplete filing of this return/rep	oort will be assessed	unless reasonable cause i	s establis	shed.		
		penalties set forth in the instructions						
SIGN HERE	Filed with authorized/valid	electronic signature.						
HEKE	Signature of plan admin	istrator	Date	Enter name of individual s	ndividual signing as plan administrator			
SIGN								
HERE	Signature of employer/p	lan sponsor	Date	ate Enter name of individual sign		employer or plan sp	onsor	
SIGN								
HERE Signature of DFE Date Enter name of individual signin-						DFE		
Preparer	's name (including firm nam	ne, if applicable) and address (include	e room or suite numbe		reparer's optional)	telephone number		

Form 5500 (2014) Page **2** 

3a	Plan administrator's name and address XSame as Plan Sponsor		<b>3b</b> Administrator's EIN		
			3c Admini- numbe	strator's telephone r	
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed EIN and the plan number from the last return/report:	d 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	120	
6	Number of participants as of the end of the plan year unless otherwise stated (welfare p 6a(2), 6b, 6c, and 6d).	plans complete only lines 6a(1),			
a(′	1) Total number of active participants at the beginning of the plan year		6a(1)	120	
a(2	2) Total number of active participants at the end of the plan year		6a(2)	120	
b	Retired or separated participants receiving benefits		6b		
С	Other retired or separated participants entitled to future benefits		6c		
d	Subtotal. Add lines 6a(2), 6b, and 6c.		6d	120	
е	Deceased participants whose beneficiaries are receiving or are entitled to receive beneficiaries	fits	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 define complete this item)		6g		
h	Number of participants that terminated employment during the plan year with accrued b less than 100% vested		6h		
7	Enter the total number of employers obligated to contribute to the plan (only multiemplo	yer plans complete this item)	7		
b	If the plan provides pension benefits, enter the applicable pension feature codes from the lift the plan provides welfare benefits, enter the applicable welfare feature codes from the lift the plan provides welfare benefits, enter the applicable welfare feature codes from the lift the plan provides welfare benefits, enter the applicable welfare feature codes from the lift the plan provides welfare benefits, enter the applicable welfare feature codes from the lift the plan provides welfare benefits, enter the applicable welfare feature codes from the lift the plan provides welfare benefits, enter the applicable welfare feature codes from the lift the plan provides welfare benefits, enter the applicable welfare feature codes from the lift the plan provides welfare benefits, enter the applicable welfare feature codes from the lift the plan provides welfare benefits, enter the applicable welfare feature codes from the lift the plan provides welfare benefits, enter the applicable welfare feature codes from the lift the plan provides welfare benefits and the lift the lift the plan provides welfare benefits and the lift the li	e List of Plan Characteristics Codes	s in the instru		
9a	Plan funding arrangement (check all that apply)  (1)  Insurance  9b Plan (1)  (1)	n benefit arrangement (check all tha	at apply)		
	(1) Code section 412(e)(3) insurance contracts (2)	Insurance Code section 412(e)(3)	nsurance co	ontracts	
	(3) Trust (3)	Trust	nourance ee	maoto	
	(4) General assets of the sponsor (4)	General assets of the sp	onsor		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, an	nd, where indicated, enter the numb	er attached.	(See instructions)	
а	Pension Schedules b Ger	neral Schedules			
	(1) R (Retirement Plan Information) (1)	H (Financial Inform	nation)		
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money (2)	I (Financial Inform	ation – Sma	ıll Plan)	
	Purchase Plan Actuarial Information) - signed by the plan  (3)	X 6 A (Insurance Infor		<del>,</del>	
	actuary (4)	C (Service Provide	,	n)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial (5)	<b>D</b> (DFE/Participati			
	Information) - signed by the plan actuary (6)	<b>G</b> (Financial Trans	action Sche	dules)	
		<u> </u>			

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 Confirma	ation Code				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

Insurance companies are required to provide the information

OMB No. 1210-0110

2014

pursuant to ERISA section 103(a)(2).					Inspection	
For calendar plan year 20	14 or fiscal pla	in year beginning 07/01/2014	and e	ending 06/30/2015		
A Name of plan INLAND TELEPHONE CO	MPANY WEL	FARE BENEFIT PLAN		ee-digit n number (PN)	501	
C Plan sponsor's name as shown on line 2a of Form 5500 INLAND TELEPHONE COMPANY  D Employer Identification Number (EIN) 91-0449170						
	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 WA	SHINGTON					
/L\	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To	
91-0621480	47341	433	297	297 07/01/2014		
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. List in line	3 the agents, brokers, and	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						
3453 0						
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all persons).			
0001/501/0 101/50 05			r, or other person to whom commis	sions or fees were paid		
CORKERY & JONES BE	NEFITS INC.		W. RIVERSIDE AVE. STE 800 KANE, WA 99201			
(b) Amount of sales ar	nd hase	Fe	es and other commissions paid			
commissions pa	id	(c) Amount	(d) Purpo	(e) Organization code		
	3453				3	
	(a) Namo	and address of the agent, broke	r or other person to whom commis	esions or foos wore paid	·	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(b) Amount of sales ar			ees and other commissions paid			
commissions pa	id	(c) Amount	(d) Purpo	se	(e) Organization code	

Schedule A (Form 5500) 2014 Page <b>2 -</b> 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
	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.	th each carrier may b	e treate	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 coretention 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 deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check	here •		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separa	ate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation g	uarantee		
	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)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2) 7e(3)			
		(3) Transferred to separate account	7e(4)			
		(4) Other (specify below)	/ ( 4 )			
		•				
					70(F)	
	f	(5) Total deductions			7e(5) 7f	0
	1	balance at the end of the current year (Subtract line re(3) from line rd)			7.1	

Page <b>4</b>	
employer(s) or members of the same en operience-rated as a unit. Where contract d as a unit for purposes of this report.	
c ☐ Vision g ☐ Supplemental unemployment k ☐ PPO contract	d Life insurance h Prescription drug l Indemnity contract
2/1) 11518	

Pá	art III	Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same gr information may be combined for reporting po	urposes if such contracts	are experienc	e-rated as a unit. Wh	ere contract		
		the entire group of such individual contracts v	with each carrier may be t	reated as a u	nit for purposes of this	report.		
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> X Dental	С	Vision		d 🔲 Li	ife insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	y <b>g</b>	Supplemental unemp	ployment	<b>h</b> $\square$ P	rescription drug
	i Ē	Stop loss (large deductible)	j  HMO contract	k 🗆	PPO contract		I ☐ In	demnity contract
	m	Other (specify)	· L					·
	∟	_ Guier (openity) /						
9	Expe	rience-rated contracts:						
		Premiums: (1) Amount received		9a(1)		115189		
		(2) Increase (decrease) in amount due but unpaid	d	9a(2)				
		(3) Increase (decrease) in unearned premium res	serve	9a(3)				
		(4) Earned ( <b>(1) + (2) - (3)</b> )				9a(4)		115189
	b	Benefit charges (1) Claims paid		9b(1)		96071		
		(2) Increase (decrease) in claim reserves		9b(2)		-1000		
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		95071
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)		3453		
		(B) Administrative service or other fees		9c(1)(B)		18317		
		(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)		21770
		(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)		4000
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2).	.)	. 9e		
10	<b>)</b> Nor	nexperience-rated contracts:						
	_	Total premiums or subscription charges paid to o				10a		
		If the carrier, service, or other organization incurr	, .			401-		
		retention of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	ount	10b	1	

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

Specify nature of costs >

Schedule A (Form 5500) 2014

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2014

pursuant to ERISA section 103(a)(2).				inspection			
For calendar plan year 20°	14 or fiscal pla	n year beginning 07/01/2014		and en	ding 06	6/30/2015	
A Name of plan INLAND TELEPHONE CO	MPANY WELI	FARE BENEFIT PLAN			e-digit number (P	PN) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 INLAND TELEPHONE COMPANY  D Employer Identification Number (Ell 91-0449170						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						
UNUM LIFE INSURANCE	E COMPANY (	OF AMERICA					
/LV FINI	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	) From	<b>(g)</b> To
01-0278678	62235	R0275404		0	07/01/20	014	06/30/2015
2 Insurance fee and comp 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	amount of com			<b>(b)</b> To	tal amount	t of fees paid	
		0					0
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fee	s were paid	
(b) Amount of sales ar	nd base	Ęe	es and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose		(e) Organization code		
	(a) Name a	and address of the agent, broke	r. or other person to who	m commissi	ions or fee	s were paid	
	(2)	aga, s	, o. e.i.e. poiee. le iiie			o noto pala	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code

Schedule A (Form 5500) 2014 Page <b>2 -</b> 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) 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 wi	th each carrier may b	e treate	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 coretention 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 deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check	here •		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separa	ate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation g	uarantee		
	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)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2) 7e(3)			
		(3) Transferred to separate account	7e(4)			
		(4) Other (specify below)	/ ( 4 )			
		•				
					70(F)	
	f	(5) Total deductions			7e(5) 7f	0
	1	balance at the end of the current year (Subtract line re(3) from line rd)			7.1	

Schedule A (Form 5500) 2014		Pag	ge <b>4</b>	
Welfare Benefit Contract Informatif 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 sar urposes if such contracts are	e experienc	e-rated as a unit. Where contra	
efit and contract type (check all applicable boxes)	1			
Health (other than dental or vision)	<b>b</b> Dental	с∏	Vision	<b>d</b> X Life insurance
Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemployment	h Prescription drug
Stop loss (large deductible)	j  HMO contract	k ☐	PPO contract	I Indemnity contract
Other (specify) AD&D	_	_		_
erience-rated contracts:				
Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unpai		9a(2)		
(3) Increase (decrease) in unearned premium res		9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)	
Benefit charges (1) Claims paid		9b(1)	•	
(2) Increase (decrease) in claim reserves		9b(2)		
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
Remainder of premium: (1) Retention charges (	on an accrual basis)			
(A) Commissions	<u>g</u>	c(1)(A)		
(B) Administrative service or other fees	g	c(1)(B)		

9c(1)(H)

9c(2)

9d(1)

9d(2)

9d(3)

9e

10a

10b

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)

m X Other (specify) ▶AD&D

Experience-rated contracts:

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

(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 th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

9c(1)(C)

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

9c(1)(F)

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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Insurance companies are required to provide the information

OMB No. 1210-0110

2014

			ERISA section 103(a)(2).	lation	Inspection		
For calendar plan year 20	14 or fiscal pla	n year beginning 07/01/2014	and o	ending 06/30/2015			
A Name of plan INLAND TELEPHONE COMPANY WELFARE BENEFIT PLAN  B Three-digit plan number (PN)					501		
C Plan sponsor's name as shown on line 2a of Form 5500 INLAND TELEPHONE COMPANY  D Employer Identification Number (EIN) 91-0449170					er (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						
STANDARD INSURANC	E COMPANY						
(b) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year		
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To		
93-0242990	69019	156299	41	07/01/2014	06/30/2015		
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. List in line	3 the agents, brokers, and	I other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid							
	1747 0						
3 Persons receiving com			s as needed to report all persons)				
CORKERY & JONES BE		•	r, or other person to whom commis W RIVERSIDE AVE STE 800	ssions or fees were paid			
CONNENT & JONES BE	INELLITO INC.		KANE, WA 99201				
<b>(b)</b> Amount of sales a	nd hase	Fe	es and other commissions paid				
commissions pa		(c) Amount	(d) Purpo	(e) Organization code			
	1747				3		
	(a) Name -						
	(a) Name a	and address of the agent, broke	r, or other person to whom commi-	ssions or rees were paid			
(b) Amount of sales ar	nd base	Fe	es and other commissions paid				
commissions pa		(c) Amount	(d) Purpo	ose	(e) Organization code		

Schedule A (Form 5500) 2014 Page <b>2 -</b> 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) 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 wi	th each carrier may b	e treate	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 coretention 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 deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check	here •		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separa	ate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation g	uarantee		
	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)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2) 7e(3)			
		(3) Transferred to separate account	7e(4)			
		(4) Other (specify below)	/ ( 4 )			
		•				
					70(F)	
	f	(5) Total deductions			7e(5) 7f	0
	1	balance at the end of the current year (Subtract line re(3) from line rd)			7.1	

Schedule A (Form 5500) 2014		Page <b>4</b>	
Welfare Benefit Contract Information If more than one contract covers the same guinformation may be combined for reporting put the entire group of such individual contracts of the same group of the same group of such individual contracts of the same group of the same gr	roup of employees of the same urposes if such contracts are	experience-rated as a unit. Where contra	. ,
and contract type (check all applicable boxes)			
lealth (other than dental or vision)	<b>b</b> Dental	<b>c</b>	<b>d</b> X Life insurance
emporary disability (accident and sickness)	f Long-term disability	<b>g</b> Supplemental unemployment	<b>h</b> Prescription drug
top loss (large deductible)	j HMO contract	<b>k</b> PPO contract	I Indemnity contract
Other (specify)	_	_	_

employees,

(	е [	Temporary disability (accident and sickness)	f Long-term disability	ty <b>g</b>	Supplemental unemp	oloyment <b>i</b>	Prescription drug
i	i [	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)			_		_
	L	] (cp-say)					
Е	хрє	rience-rated contracts:					
á	a I	remiums: (1) Amount received		9a(1)		26101	
		(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)	26101
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)		42805	
		(3) Incurred claims (add (1) and (2))				9b(3)	42805
		(4) Claims charged				9b(4)	42805
	С	Remainder of premium: (1) Retention charges (	on an accrual basis)				
		(A) Commissions		9c(1)(A)		1747	
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)		2929	
		(E) Taxes		9c(1)(E)		522	
		(F) Charges for risks or other contingencies		9c(1)(F)		1827	
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	7025
		(2) Dividends or retroactive rate refunds. (Thes	e 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	r retirement	9d(1)	
		(2) Claim reserves				9d(2)	48331
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do r	not include amount entered	d in line <b>9c(2)</b>	).)	9e	
0	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to	carrier			10a	
	b	If the carrier, service, or other organization incu			-	401	
		retention of the contract or policy other than rer	norted in Part I line 2 above	a report amo	ount	10h	1

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

8 Benefit and contract type (check all applicable boxes)

a Health (other than dental or vision)

Specify nature of costs

Part III

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2014

		pursuant to	ERISA section 103(a)(2).				inspection
For calendar plan year 20	14 or fiscal pla	n year beginning 07/01/2014	_	and endi	ing 06	6/30/2015	
A Name of plan INLAND TELEPHONE CO	A Name of plan INLAND TELEPHONE COMPANY WELFARE BENEFIT PLAN			3 Three- plan n	digit iumber (P	N) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 INLAND TELEPHONE COMPANY  D Employer Identification N 91-0449170				cation Number (	EIN)		
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
STANDARD INSURANC	E COMPANY						
# . =	(c) NAIC	(d) Contract or	(e) Approximate num			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at e policy or contract y		<b>(</b> f)	From	<b>(g)</b> To
93-0242990	69019	156299	41		07/01/20	014	06/30/2015
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. List	in line 3 th	ne agents,	, brokers, and ot	her persons in
(a) Total	amount of com	missions paid		(b) Tota	al amount	of fees paid	
		1972					0
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all pe	rsons).			
	(a) Name a	and address of the agent, broker	, or other person to whom	commissio	ns or fees	s were paid	
CORKERY & JONES BE	NEFITS INC.		W RIVERSIDE AVE STE 8 KANE, WA 99201	00			
			es and other commissions	naid			
(b) Amount of sales are commissions pa		(c) Amount		Purpose			(e) Organization code
	1972	,	(a) Turpose				3
	(a) Name a	and address of the agent, broker	, or other person to whom	commissio	ns or fees	s were paid	
(b) Amount of sales a	nd base	Fe	es and other commissions	paid			
commissions pa		(c) Amount	(d)	Purpose			(e) Organization code

Schedule A (Form 5500)	Schedule A (Form 5500) 2014 Page <b>2 -</b> 1				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(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.	idual contracts wi	th each carrier may b	e treate	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	
_	Contracts 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 coretention 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 deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check	here •		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separa	ate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation g	uarantee		
	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)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2) 7e(3)			
		(3) Transferred to separate account	7e(4)			
		(4) Other (specify below)	/ C(4)			
		•				
					70(F)	
	f	(5) Total deductions			7e(5) 7f	0
	1	balance at the end of the current year (Subtract line re(3) from line rd)			7.1	

Schedule A (Form 5500) 2014		Page	e <b>4</b>	
Part III Welfare Benefit Contract Informa If more than one contract covers the same go information may be combined for reporting the entire group of such individual contracts	group of employees of the sar ourposes if such contracts are	e experience	-rated as a unit. Where contra	
8 Benefit and contract type (check all applicable boxes	s)			
a ☐ Health (other than dental or vision)	<b>b</b> Dental	с□	Vision	<b>d</b> Life insurance
e Temporary disability (accident and sickness)	f X Long-term disability	느	Supplemental unemployment	h Prescription drug
				<b>=</b>
i Stop loss (large deductible)	j HMO contract	ĸ	PPO contract	I Indemnity contract
m ☐ Other (specify) ▶				
_				
9 Experience-rated contracts:				
a Premiums: (1) Amount received		9a(1)	1643	35
(2) Increase (decrease) in amount due but unpa		9a(2)		
(3) Increase (decrease) in unearned premium re	<u> </u>	9a(3)	0.74	1040
(4) Earned ((1) + (2) - (3))				,
<b>b</b> Benefit charges (1) Claims paid		9b(1)	1078	
(2) Increase (decrease) in claim reserves		9b(2)	7654	
(3) Incurred claims (add (1) and (2))				•
(4) Claims charged			9b(4)	87330
<b>c</b> Remainder of premium: (1) Retention charges (	· · · · · · · · · · · · · · · · · · ·			
(A) Commissions		9c(1)(A)	197	72
(B) Administrative service or other fees		9c(1)(B)		
(C) Other specific acquisition costs		0c(1)(C)		
(D) Other expenses		0c(1)(D)	333	
(E) Taxes		0c(1)(E)	32	29
(F) Charges for risks or other contingencies		9c(1)(F)	197	73
(G) Other retention charges	<u>_</u>	9c(1)(G)		
(H) Total retention			9c(1)(l	<b>H)</b> 7610
(2) Dividends or retroactive rate refunds. (Thes	e amounts were paid in ca	ash, or cr	edited.)9c(2)	)
<b>d</b> Status of policyholder reserves at end of year: (	1) Amount held to provide be	nefits after r		
(2) Claim reserves	•			

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

9d(3)

9e

10a

10b

(3) Other reserves....

e 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 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 >

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Insurance Information** 

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2014

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 20	14 or fiscal pla	n year beginning 07/01/2014	and e	ending 06/30/2015			
A Name of plan INLAND TELEPHONE CO	MPANY WEL	FARE BENEFIT PLAN		ree-digit an number (PN)	501		
C Plan sponsor's name a INLAND TELEPHONE CO		ne 2a of Form 5500		oloyer Identification Number 449170	er (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						
PROVIDENT LIFE AND	ACCIDENT IN	SURANCE COMPANY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	Policy or	contract year		
<b>(b)</b> EIN	code	identification number	policy or contract year	(f) From	<b>(g)</b> To		
62-0331200	68195	0010686986	104	07/01/2014	07/01/2015		
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. List in line	3 the agents, brokers, and	I other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid							
		645			0		
3 Persons receiving com			s as needed to report all persons).				
CORKERY & JONES BE		•	r, or other person to whom commis W RIVERSIDE AVE STE 800	ssions or fees were paid			
CORNERT & JONES BE	NEFITS INC.		W RIVERSIDE AVE STE 600 KANE, WA 99201				
(b) Amount of sales ar	nd book	Fe	ees and other commissions paid				
commissions pa		(c) Amount	(d) Purpo	(e) Organization code			
	645				3		
	(a) Name	and address of the agent, broke	r, or other person to whom commis	ssions or fees were paid			
(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount	(d) Purpo	ose	(e) Organization code		

Schedule A (Form 5500)	Schedule A (Form 5500) 2014 Page <b>2 -</b> 1				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(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.	idual contracts wi	th each carrier may b	e treate	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	
_	Contracts 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 coretention 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 deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check	here •		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separa	ate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation g	uarantee		
	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)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2) 7e(3)			
		(3) Transferred to separate account	7e(4)			
		(4) Other (specify below)	/ C(4)			
		•				
					70(F)	
	f	(5) Total deductions			7e(5) 7f	0
	1	balance at the end of the current year (Subtract line re(3) from line rd)			7.1	

Schedule A (Form 5500) 2014		Page <b>4</b>		
Welfare Benefit Contract Infor If more than one contract covers the sar information may be combined for reporti the entire group of such individual contra	ne group of employees of the s ng purposes if such contracts a	are experience-rated	as a unit. Where contract	
Benefit and contract type (check all applicable bo	xes)			
a Health (other than dental or vision)	<b>b</b> Dental	<b>c</b> Vision		<b>d</b> Life insurance
e Temporary disability (accident and sicknes	ss) <b>f</b> Long-term disabilit	y <b>g</b> ☐ Supple	mental unemployment	<b>h</b> ☐ Prescription drug
i Stop loss (large deductible)	j HMO contract	k ∏ PPO c		I Indemnity contract
m X Other (specify) ►ACCIDENT, ISTDPROT	· -			
Experience-rated contracts:				
a Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but u	npaid	9a(2)		
(3) Increase (decrease) in unearned premiur	n reserve			
(4) Earned ((1) + (2) - (3))	•		9a(4)	
<b>b</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 charg	es (on an accrual basis)			
(A) Commissions	·	9c(1)(A)		
(B) Administrative service or other fees.		9c(1)(B)		
(0) Other and all a second all a second		9c(1)(C)		Ti .

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

30536

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

10 Nonexperience-rated contracts:

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

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

(D) Other expenses.....

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

(H) Total retention.....

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

(2) Claim reserves .....

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

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

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

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

Part III

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

9c(1)(D)

9c(1)(E)

9c(1)(F)

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

Insurance companies are required to provide the information

OMB No. 1210-0110

2014

pursuant to ERISA section 103(a)(2).					Inspection	
For calendar plan year 20	14 or fiscal pla	n year beginning 07/01/2014	and e	nding 06/30/2015		
A Name of plan INLAND TELEPHONE CO	MPANY WEL	FARE BENEFIT PLAN		ee-digit n number (PN)	501	
C Plan sponsor's name a INLAND TELEPHONE CO		ne 2a of Form 5500		oyer Identification Numbe 49170	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					
HARTFORD LIFE AND A	CCIDENT					
<b>(b)</b> FINI	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	Policy or	contract year	
<b>(b)</b> EIN	code	identification number	policy or contract year	(f) From	<b>(g)</b> To	
06-0838648	70815	ETB-144007	120	07/01/2014	06/30/2014	
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. List in line 3	3 the agents, brokers, and	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						
	113 0					
3 Persons receiving com			s as needed to report all persons).			
CORKERY & JONES BE		•	r, or other person to whom commis: W RIVERSIDE AVE STE 800	sions or fees were paid		
CONNENT & JONES BE	NEI II O INO.		OKANE, WA 99201			
(b) Amount of sales ar	nd hase	Fe	ees and other commissions paid			
commissions pa	id	(c) Amount	(d) Purpos	(d) Purpose		
	113				3	
	(a) Name :	and address of the agent, broke	r, or other person to whom commis	sions or fees were paid		
	(a) Hamo	and address of the agent, protes	i, or outer percent to whem comme	olono or roco woro para		
(b) Amount of sales and base Fees and other commissions paid						
commissions pa		(c) Amount	(d) Purpos	se	(e) Organization code	

Schedule A (Form 5500) 2014 Page <b>2 -</b> 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid	•		
(a) Na	ine 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)			
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		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.	idual contracts wit	th 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 coretention 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 deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check	here •		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separa	ate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation gu	uarantee		
	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)			
		•				
				-	/_/C\	0
	٨	(6)Total additions			′c(6) 7d	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7 u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(1)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>)</b>				
		•				
				_	/-/F\	
	f	(5) Total deductions			'e(5) 7f	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<i>/</i> I	

Schedule A (Form 5500) 2014	Page <b>4</b>	
information may be combined for repo	mation  le group of employees of the same employer(s) or members of the same employee organization  g purposes if such contracts are experience-rated as a unit. Where contracts cover individual  cts with each carrier may be treated as a unit for purposes of this report.	
Benefit and contract type (check all applicable	res)	
a Health (other than dental or vision)	b ☐ Dental	се
e Temporary disability (accident and sickn	s) <b>f</b> Long-term disability <b>g</b> Supplemental unemployment <b>h</b> Prescription	drug
i Stop loss (large deductible)	j	
m ☒ Other (specify) ▶BUSINESS TRAVEL		
III A canon (openiny) / Deciritates manual		
Experience-rated contracts:		
a Premiums: (1) Amount received	9a(1)	
(2) Increase (decrease) in amount due but	paid	
(3) Increase (decrease) in unearned premi	n reserve	
(4) Earned ((1) + (2) - (3))	9a(4)	
<b>b</b> Benefit charges (1) Claims paid	9b(1)	
(2) Increase (decrease) in claim reserves.	9b(2)	
(3) Incurred claims (add (1) and (2))	9b(3)	
(4) Claims charged	9b(4)	
c Remainder of premium: (1) Retention cha	es (on an accrual basis)	
(A) Commissions	9c(1)(A)	
(B) Administrative service or other fee	9c(1)(B)	
(C) Other specific acquisition costs	9c(1)(C)	

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

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)

(D) Other expenses.....

(E) Taxes.....

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

(H) Total retention.....

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

(2) Claim reserves .....

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

Total premiums or subscription charges paid to carrier ...... If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

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

Part III

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

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

9c(1)(F)

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

## Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Fension 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 - 0069

2014

This Form is Open to Public Inspection

Part I Annual Report Identification Information	
	ending 06/30/2015
a single-employer plan; participating employer a DFE (specify)	an (Filers checking this box must attach a list of rinformation in accordance with the forms instr.); or
B This return/report is: the first return/report; the final return/report;	
an amended return/report; a short plan year return.  C If the plan is a collectively-bargained plan, check here	n/report (less than 12 months).
D Check box if filing under: Form 5558; automatic extension; special extension (enter description)	the DFVC program;
Part II Basic Plan Information - enter all requested information	
1a Name of plan INLAND TELEPHONE COMPANY	1b Three-digit plan number (PN) ► 501
WELFARE BENEFIT PLAN	1c Effective date of plan 06/01/2006
28 Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)	2b Employer Identification Number (EIN) 91-0449170
INLAND TELEPHONE COMPANY	2c Plan Sponsor's telephone number (509) 649-2211
P. O. BOX 171	2d Business code (see instructions) 517000
ROSLYN WA 98941 103 SOUTH 2ND STREET	
ROSLYN WA 98941 Caution: A penalty for the late or incomplete filing of this return/report will be assessed unles	s 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 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 JAMES K.	BROOKS
	vidual signing as plan administrator
SIGN AMES K. JAMES K.	BROOKS
Signature of employer/plan sponsor Date Enter name of indiv	vidual signing as employer or plan sponsor
SIGN	
Signature of DFE Date Enter name of indiv	vidual signing as DFE
Preparer's name (including firm name, if applicable) and address (include room or suite number) (of	ptional) Preparer's telephone number (optional)
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Forn	n 5500. Form 5500 (2014)

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ron	m 5500 (2014)	<del></del> .			PE	age 2				
3a	Plan administrator's name and address 🔀 Same as Plan Sponsor	nistrator's name and address 🗵 Same as Plan Sponsor				rator's EIN				
						3c /	Administ	trator's telephone number		
4	If the name and/or EIN of the plan sponsor has changed since the last return	v/report	file	d for th	is pla	n, ente	r the na	me,	4b EIN	
	EiN and the plan number from the last return/report:								4c PN	
а	Sponsor's name								40 14	
5	Total number of participants at the beginning of the plan year							5		120
<del>5</del>	Number of participants as of the end of the plan year unless otherwise states	d (welfa	re t	olans co	elgmo	te only	lines		, ,	
•	8a(1), 6a(2), 6b, 6c, and 6d).	_ (	,							* :
а	(1) Total number of active participants at the beginning of the plan year		. <b>.</b>	<b></b>		•••••		6a(1)		120
	(2) Total number of active participants at the end of the plan year							6a(2)		120
	Retired or separated participants receiving benefits							6b		
	Other retired or separated participants entitled to future benefits							6c		
d	Subtotal. Add lines 6a(2), 6b, and 6c					••••		6d		120
8	Deceased participants whose beneficiaries are receiving or are entitled to rec	eive be	nei	its		•••••	•••••	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 de	əfin	ed cont	tributi	on pla	าร			
	complete this item)	•••••	••••					6g		
h	Number of participants that terminated employment during the plan year with							6h		
	100% vested	***********					*******	On		
7	Enter the total number of employers obligated to contribute to the plan (only							7		
	complete this item)				of Dia	- Cha	notoriet	<u> </u>	ee in the inst	n ctions:
8a	If the plan provides pension benefits, enter the applicable pension feature co	ides troi								
8a b 4B	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could $4D\ 4F\ 4H\ 4L$				f Plan	Chara				
b 4B	If the plan provides welfare benefits, enter the applicable welfare feature ${ t cod}$ ${ t 4D}$ ${ t 4F}$ ${ t 4H}$ ${ t 4L}$	es from Plan b	the ene	List of				s Code:	s in the instru	
b 4B	If the plan provides welfare benefits, enter the applicable welfare feature code $4D$ $4F$ $4H$ $4L$	es from	the ene	List of	ngeme	ent (ch	cteristic	s Code:	s in the instru	
b 4B	If the plan provides welfare benefits, enter the applicable welfare feature code 4D 4F 4H 4L  Plan funding arrangement (check all that apply)  9b	Plan b	the ene	List of	ngeme	ent (ch	cteristic	s Code:	s in the instru	
b 4B	If the plan provides welfare benefits, enter the applicable welfare feature code 4D 4F 4H 4L  Plan funding arrangement (check all that apply)  (1) X insurance	es from Plan b	the ene	fit arrar Insurar Code s	ngeme nce section	ent (ch	cteristic eck all ti e)(3) insu	s Codes	s in the instru	
b 4B 9a	If the plan provides welfare benefits, enter the applicable welfare feature code 4D 4F 4H 4L  Plan funding arrangement (check all that apply)  (1) X Insurance (2) Code section 412(e)(3) insurance contracts  Trust (4) General assets of the sponsor	Plan b (1) (2) (3) (4)	ene	fit arrar Insurar Code s Trust Genera	ngeme nce section	ent (ch n 412(e	cteristic eck all ti e)(3) insu	s Code: hat app urance o	s in the instru ly) contracts	octions:
b 4B 9a	If the plan provides welfare benefits, enter the applicable welfare feature code 4D 4F 4H 4L  Plan funding arrangement (check all that apply)  (1) X Insurance  (2) Code section 412(e)(3) insurance contracts  Trust	Plan b (1) (2) (3) (4)	ene	fit arrar Insurar Code s Trust Genera	ngeme nce section	ent (ch n 412(e	cteristic eck all ti e)(3) insu	s Code: hat app urance o	s in the instru ly) contracts	octions:
b 4B 9a	If the plan provides welfare benefits, enter the applicable welfare feature code 4D 4F 4H 4L  Plan funding arrangement (check all that apply)  (1)	Plan b (1) (2) (3) (4)	ene X	e List of fit arrar Insurar Code s Trust Genera nd, whe	ngeme nce section al asse re ind	ent (ch n 412(e	cteristic eck all ti e)(3) insu	s Code: hat app urance o	s in the instru ly) contracts	octions:
b 4B 9a	If the plan provides welfare benefits, enter the applicable welfare feature code 4D 4F 4H 4L  Plan funding arrangement (check all that apply)  (1)	Plan b (1) (2) (3) (4)	ene X	e List of fit arrar Insurar Code s Trust Genera nd, whe	ngeme nce section al asse re ind	ent (ch n 412(c ets of t licated (Fina	eck all ti e)(3) insu he spon enter ti	hat appurance of sor	s in the instru ly) contracts ber attached	ictions:
b 4B 9a	If the plan provides welfare benefits, enter the applicable welfare feature code 4D 4F 4H 4L  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  Check all applicable boxes in 10a and 10b to indicate which schedules are at (See instructions)  Pension Schedules  (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money)	Plan b (1) (2) (3) (4) ttached Genee (1) (2)	ene X	offit arrar Insurar Code s Trust Genera nd, whe	ngeme nce section al asse re ind	ent (ch n 412(d ets of t licated (Fina (Fina	eck all ti e)(3) insu he spon , enter ti ncial Info	s Code: hat app urance of sor he number ormatio ormatio	s in the instru ly) contracts ber attached n) n - Small Plar	ictions:
b 4B 9a	If the plan provides welfare benefits, enter the applicable welfare feature code 4D 4F 4H 4L  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  Check all applicable boxes in 10a and 10b to indicate which schedules are all (See instructions)  Pension Schedules  (1) R (Retirement Plan Information)  (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	Plan b (1) (2) (3) (4) ttached (1) (2) (3)	ene X	e List of fit arrar Insurar Code s Trust Genera nd, whe	ngeme section al asse re ind ules H I A	ets of t licated (Fina (Insu	eck all the spon, enter the neial Information Informat	hat appurance of sormatio ormatio of formation of the second of the seco	s in the instru ly) contracts ber attached n) n - Small Plar on)	ictions:
b 4B 9a	If the plan provides welfare benefits, enter the applicable welfare feature code 4D 4F 4H 4L  Plan funding arrangement (check all that apply)  (1)	Plan b (1) (2) (3) (4) ttached (1) (2) (3) (4)	ene X	offit arrar Insurar Code s Trust Genera nd, whe	ngeme section al asse re ind ules H I A	ent (ch n 412(d ets of t licated (Fina (Fina (Insu (Serv	eck all the spon and a spon a spon a spon a spon a spon and a spon a spo	hat appurance of sormatio ormatio of formatio der Infinite Control of the Control	s in the instru ly) contracts ber attached n) n - Small Plar on) ormation)	nctions:
b 4B 9a	If the plan provides welfare benefits, enter the applicable welfare feature code 4D 4F 4H 4L  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  Check all applicable boxes in 10a and 10b to indicate which schedules are all (See instructions)  Pension Schedules  (1) R (Retirement Plan Information)  (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	Plan b (1) (2) (3) (4) ttached (1) (2) (3)	ene X	offit arrar Insurar Code s Trust Genera nd, whe	ngeme section al asse re ind ules H I A	ent (chan 412) ets of t licated (Fina (Fina (Insu (Serv (DFE	eck all the spon and a spon a sp	hat appurance of sormatio ormatio of ormatio if ormatio item at the second seco	s in the instru ly) contracts ber attached n) n - Small Plar on)	nctions:

Form 5500	0 (2014)	Page 3	
Part III	Form M-1 Compliance Informat	tion (to be completed by welfare benefit plans)	
CFR 2520.	the plan provides welfare benefits, was the plan p.101-2.) Yes checked, complete lines 11b and 11c.	n subject to the Form M-1 filing requirements during the plan year? (See instructions an	<del>,</del>
11h (e the	he plan currently in compliance with the Form	M-1 filing requirements? (See Instructions and 29 CFR 2520.101-2.) Yes	No
enter the A	Receipt Confirmation Code for the most receipt	4 Form M·1 annual report. If the plan was not required to file the 2014 Form M·1 annual nt Form M·1 that was required to be filed under the Form M·1 filing requirements. (Failure the Form 5500 filing to rejection as incomplete.)	е
Receipt Co	Confirmation Code		

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