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	Annual Report Ide	entification Information						
For cale	ndar plan year 2014 or fisca	al plan year beginning 01/01/2014		and ending 12/31	/2014			
A This	return/report is for:	a multiemployer plan;		e-employer plan (Filers checki ting employer information in a	-		ons); or	
		x a single-employer plan;	a DFE (specify)				
B This	eturn/report is:	the first return/report;	the final	return/report;				
	·	an amended return/report;	a short	plan year return/report (less th	an 12 month	s).		
C If the	plan is a collectively-bargai	ined plan, check here				→ □		
D Chec	k box if filing under:	Form 5558;	automat	ic extension;	the DF	FVC program;		
	3	special extension (enter descriptio	n)		ш			
Part	Basic Plan Info	rmation—enter all requested informa	ation					
1a Nam	ne of plan				1b	Three-digit plan	501	
COBALT	MORTGAGE, INC. HEAL	TH & WELFARE PLAN			4-	number (PN) ▶		
					10	Effective date of p 09/14/2001	an	
	sponsor's name and address MORTGAGE, INC.	ess; include room or suite number (emp	oloyer, if for a s	ingle-employer plan)	2b	Employer Identifica Number (EIN) 91-2138037	ation	
	LATER AVE NE, SUITE 11		ATER AVE NE,	SUITE 110	2c	2c Plan Sponsor's telephone number 425-605-3100		
KIRKLAND, WA 98033 KIRKLAND, WA 98033					2d	2d Business code (see instructions) 522292		
Coution	A nanalty for the late or	incomplete filing of this return/report	rt will be acces	acad unless responsible cour	o is setablic	nhad		
		r penalties set forth in the instructions,					edules.	
		Il as the electronic version of this return						
SIGN	Filed with authorized/valid	electronic signature.						
HERE	Signature of plan admin	istrator	Date	Enter name of individua	ndividual signing as plan administrator			
SIGN								
HERE	Signature of employer/p	olan sponsor	Date	Enter name of individua	al signing as	emplover or plan sr	onsor	
	- <u>J</u>				<u> </u>			
SIGN HERE								
Signature of DFE Date Enter name of individual signing								
Preparer	's name (including firm nan	ne, if applicable) and address (include	room or suite n	umber) (optional)	Preparer's (optional)	telephone number		
1								

Form 5500 (2014) Page **2**

If the name and/or EIN of the plan approach has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report filed for this plan, enter the name, EIN and the plan plan spar and the plan plan spar and the plan plan plan spar and the plan plan plan plan plan plan spar and the plan plan plan plan plan plan plan plan	3a	Plan administrator's name and address Same as Plan Sponsor		3b Admin	istrator's EIN
Ella and the plan number from the last return/reports: a Sponsor's name 5 Total number of participants at the beginning of the plan year 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(1) 1026 a(2) Total number of active participants at the beginning of the plan year					
Ella and the plan number from the last return/reports: a Sponsor's name 5 Total number of participants at the beginning of the plan year 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(1) 1026 a(2) Total number of active participants at the beginning of the plan year					
Total number of participants at the beginning of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(1) 1026 a(2) Total number of active participants at the beginning of the plan year	4		this plan, enter the name,	4b EIN	
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year	а	Sponsor's name		4c PN	
a(1) Total number of active participants at the beginning of the plan year	5	Total number of participants at the beginning of the plan year		5	1026
b Retired or separated participants at the end of the plan year 66b c Other retired or separated participants entitled to future benefits. 6c d Subtotal. Add lines 6a(2), 6b, and 6c. 6d 1009 e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e f Total. Add lines 6d and 6e. 6f 1009 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 with account balances as of the end of the plan year with accrued benefits that were less than 100% vested. 6h 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item). 7 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4H 4Q 4D 4R 9a Plan funding arrangement (check all that apply) (1)	6		s complete only lines 6a(1),		
b Retired or separated participants receiving benefits 6b c Other retired or separated participants entitled to future benefits 6c d Subtotal. Add lines 6a(2), 6b, and 6c. 6d 1009 e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e f Total. Add lines 6d and 6e. 6f 1009 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 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item). 7 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4H 4Q 4D 4R 9a Plan funding arrangement (check all that apply) (1)	a(1	1) Total number of active participants at the beginning of the plan year		6a(1)	1026
C Other retired or separated participants entitled to future benefits	a(2	2) Total number of active participants at the end of the plan year		6a(2)	1009
d Subtotal. Add lines 6a(2), 6b, and 6c	b	Retired or separated participants receiving benefits		6b	
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e f Total. Add lines 6d and 6e. 6f 1009 g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	С	Other retired or separated participants entitled to future benefits		6c	
f Total. Add lines 6d and 6e	d	Subtotal. Add lines 6a(2), 6b, and 6c.		6d	1009
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6e	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	f	Total. Add lines 6d and 6e.		6f	1009
less than 100% vested	g			6g	
Ba If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A		less than 100% vested		6h	
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4H 4Q 4D 4R 9b Plan benefit arrangement (check all that apply) (1)			· · · · · · · · · · · · · · · · · · ·		
(1)	b	If the plan provides welfare benefits, enter the applicable welfare feature codes from the Lis 4A 4B 4H 4Q 4D 4R	st of Plan Characteristics Codes	s in the instr	
(2) Code section 412(e)(3) insurance contracts (3) Trust (4) X General assets of the sponsor (4) General assets of the sponsor (5) General assets of the sponsor (6) General assets of the sponsor (7) General assets of the sponsor (8) General assets of the sponsor (9) General assets of the sponsor (1) R (Retirement Plan Information) (1) H (Financial Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (8) SB (Single-Employer Defined Benefit Plan Actuarial (9) D (DFE/Participating Plan Information) (9) D (DFE/Participating Plan Information)	9a			at apply)	
(3) Trust (4) X General assets of the sponsor (4) General assets of the sponsor Trust General assets of the sponsor 10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) X 4 A (Insurance Information) (4) C (Service Provider Information) (3) D (DFE/Participating Plan Information)		——————————————————————————————————————	 -	nsurance co	ontracts
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial (5) D (DFE/Participating Plan Information)			Trust		
a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial b General Schedules (1) H (Financial Information) (2) I (Financial Information – Small Plan) (3) X 4 A (Insurance Information) (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information)	10				(O ' t t)
(1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial (4) Financial Information - Small Plan) 4 A (Insurance Information) C (Service Provider Information) D (DFE/Participating Plan Information)	10		vnere indicated, enter the numb	per attached	i. (See instructions)
(1) R (Final clai information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) A (Insurance Information) (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information)	а	(1) R (Retirement Plan Information)			
Purchase Plan Actuarial Information) - signed by the plan actuary (3)		(1)	☐ H (Financial Inform	nation)	
actuary (4) C (Service Provider Information) BB (Single-Employer Defined Benefit Plan Actuarial (5) D (DFE/Participating Plan Information)			`		all Plan)
(3) SB (Single-Employer Defined Benefit Plan Actuarial (5) D (DFE/Participating Plan Information)		actuary	H '	,	un)
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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

OMB No. 1210-0110

2014

This Form is Open to Public

			ERISA section 103(a)(2).	2001	Inspection	
For calendar plan year 20	14 or fiscal pla	an year beginning 01/01/2014	and e	nding 01/01/2015		
A Name of plan COBALT MORTGAGE, INC. HEALTH & WELFARE PLAN B Three-digit plan number (PN					501	
C Plan sponsor's name a COBALT MORTGAGE, IN		ne 2a of Form 5500		oyer Identification Numl 38037	per (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 INSURANCI	E COMPANY	OF AMERICA				
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	Policy	or contract year	
(b) EIN	code	identification number	policy or contract year	(f) From	(g) To	
01-0278678	62235	581354	518	01/01/2014	01/01/2015	
2 Insurance fee and com descending order of the			otal commissions paid. List in line 3	3 the agents, brokers, a	nd other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						
32499 0						
3 Persons receiving com			s as needed to report all persons).			
PATRICK J CONROY	(a) Name	600	r, or other person to whom commis STEWART ST STE 602	sions or fees were paid		
		SEA	TTLE, WA 98101			
		_				
(b) Amount of sales ar commissions pa		(c) Amount	ees and other commissions paid (d) Purpo	20	(e) Organization code	
commissions pa	32499	0	(a) 1 dipo.	3 6	(e) Organization code	
	(a) Name	and address of the agent, broke	r, or other person to whom commis	sions or fees were paid		
(b) Amount of sales ar			ees and other commissions paid			
commissions pa	id	(c) Amount	(d) Purpos	se	(e) Organization code	

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

		Schedule A (Form 5500) 2014		Pa	ge 4		
Part	III	Welfare Benefit Contract Informal 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 surposes if such contracts a	are experienc	ce-rated as a unit. Wh	nere contrac	
8 B	enefit	and contract type (check all applicable boxes))				
а		Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
е	П	Temporary disability (accident and sickness)	f Long-term disabilit	y g [Supplemental unem	ployment	h Prescription drug
i	П	Stop loss (large deductible)	i HMO contract		PPO contract		I Indemnity contract
'n		Other (specify) LIFESTYLE ACCIDENTAL I	• 🗀	<u> </u>	4	NICE	- L
	^	Other (specify) Ferrestrice Accidentation	DEATH AND DISWEMBER	XIVILINI, LIIT	STILL LIFE INSURA	ANGL	
9 E	oerie	ence-rated contracts:					
	•	emiums: (1) Amount received		9a(1)			\dashv
		Increase (decrease) in amount due but unpai	•	• • •			
	•	Increase (decrease) in unearned premium res					
	•	Earned ((1) + (2) - (3))				. 9a(4)	(
ŀ		enefit 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)	
(R	emainder 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)			

9c(1)(H)

9c(2)

9d(1)

9d(2)

9d(3)

9e

10a

10b

216659

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

(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

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.....

(2) Claim reserves

(3) Other reserves.....

10 Nonexperience-rated contracts:

Specify nature of costs

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

This Form is Open to Public Inspection

For calendar plan year 20	For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014					
A Name of plan COBALT MORTGAGE, INC. HEALTH & WELFARE PLAN				ree-digit an number (PN)	501	
C Plan sponsor's name as shown on line 2a of Form 5500 COBALT MORTGAGE, INC.				oloyer Identification Number 138037	(EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.					
1 Coverage Information:						
(a) Name of insurance ca	rrier					
DELTA DENTAL OF WA	SHINGTON					
(L) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or c	ontract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To	
91-0621480	47341	883	402	01/01/2014	12/31/2014	
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	I commissions paid. List in line	3 the agents, brokers, and o	ther persons in	
(a) Total a	amount of comn		(b)	Total amount of fees paid		
-		21673			0	
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all persons)			
ALLIANT INCLIDANCE O		nd address of the agent, broker,		ssions or fees were paid		
ALLIANT INSURANCE S	ERVICES		LIVE WAY STE 1700 FLE, WA 98101			
					1	
(b) Amount of sales ar			s and other commissions paid	(a) Organization and		
commissions pa	10837	(c) Amount	(d) Purpo	ose	(e) Organization code	
	(a) Name a	nd address of the agent, broker,	or other person to whom commi	ssions or fees were paid		
PATRICK J. CONROY	(4)	600 S	FEWART ST STE 602 FLE, WA 98101			
SEATTLE, WASSIST						
(b) Amount of color or	ad base	Fees	s and other commissions paid			
(b) Amount of sales and base commissions paid (c) Amount		(c) Amount	(d) Purpo	ose	(e) Organization code	
10837 0						
For Panerwork Poductio	n Act Notice o	nd OMB Control Numbers, see	the instructions for Form FER	0		
i oi i aperwork neudcho	III ACI NULICE d	ina Civid Control Numbers, See	the manuchons for Form 330	Sche	dule A (Form 5500) 2014	

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		
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(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	
_		tracts With Allocated Funds:			•	1
	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	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Schedule A (Form 5500) 2014		Pag	e 4	
Welfare Benefit Contract Informal If more than one contract covers the same ginformation may be combined for reporting the entire group of such individual contracts	group of employees of the sourposes if such contracts a	are experience	e-rated as a unit. Where contra	. , , , , , , , , , , , , , , , , , , ,
and contract type (check all applicable boxes	;)			
ealth (other than dental or vision)	b X Dental	С	Vision	d Life insurance
emporary disability (accident and sickness)	f Long-term disability	y g 🗍	Supplemental unemployment	h Prescription drug
top loss (large deductible)	j HMO contract	=	PPO contract	I Indemnity contract
Other (specify)				
ice-rated contracts:	r			
niums: (1) Amount received		9a(1)	46029	94
Increase (decrease) in amount due but unpa	id	9a(2)		
Increase (decrease) in unearned premium re	serve	9a(3)		
Earned ((1) + (2) - (3))	-		9a(4)	460294
nefit charges (1) Claims paid		9b(1)	36925	51
Increase (decrease) in claim reserves		9b(2)	1050	00
Incurred claims (add (1) and (2))	_		9b(3)	379751
Claims charged			9b(4)	
mainder of premium: (1) Retention charges (
(4) 0		0~/4\/A\	0.10	

8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) **b** X Dental Temporary disability (accident and sickness) Long-term disability Stop loss (large deductible) **HMO** contract m ☐ Other (specify) ▶ 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)) (4) Claims charged Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions 9c(1)(A) 9c(1)(B) 29420 (B) Administrative service or other fees..... 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..... 51093 (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) 10500 (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 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	

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

		pursuant to E	ERISA section 103(a)(2).		inspection		
For calendar plan year 20	14 or fiscal plar	n year beginning 01/01/2014	and er	nding 12/31/2014			
A Name of plan COBALT MORTGAGE, IN	IC. HEALTH &	WELFARE PLAN		ee-digit n number (PN)	501		
C Plan sponsor's name a COBALT MORTGAGE, IN		e 2a of Form 5500		oyer Identification Numbe 38037	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						
UNITED HEALTHCARE	INSURANCE C	COMPANY					
# N FINI	(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	(g) To		
36-2739571	79413	716115	515	01/01/2014	12/31/2014		
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tot	al commissions paid. List in line 3	the agents, brokers, and	other persons in		
(a) Total a	amount of comr		(b) ⊤	otal amount of fees paid			
		121549			0		
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all persons).				
			or other person to whom commiss	sions or fees were paid			
ALLIANT INSURANCE S	ERVICES INC		DOVE STREET 200 PORT BEACH, CA 92660				
(In) Assessed of a classes		Fee	es and other commissions paid				
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purpos	(e) Organization code			
·		26500 B	ONUS				
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
PATRICK J CONROY	· · · · · · · · · · · · · · · · · · ·						
(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount	(d) Purpos	e	(e) Organization code		
	88899	0			3		

Schedule A (Form 5500)	2014	Page 2 - 1	
		r, or other person to whom commissions or fees were paid	<u> </u>
ALLIANT INSURANCE SERVICES IN		LIVE WAY STE 1700 TLE, WA 98101	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
32649			3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	I
(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	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base commissions paid		Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	ı
· ·			
(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

(c) Amount

(b) Amount of sales and base commissions paid

Fees and other commissions paid

(d) Purpose

(e) Organization 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	
_		tracts With Allocated Funds:			•	1
	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	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Schedule A (Form 5500) 2014		Page 4	
Welfare Benefit Contract Informal If more than one contract covers the same of information may be combined for reporting the entire group of such individual contracts	group of employees of the same ourposes if such contracts are e	experience-rated as a unit. Where contra	. ,
and contract type (check all applicable boxes	s)		
lealth (other than dental or vision)	b Dental	C Vision	d Life insurance
emporary disability (accident and sickness)	f Long-term disability	□ Supplemental unemployment	h Prescription drug

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 disability	g	Supplemental unemp	oloyment	h Prescription drug	
	i į	Stop loss (large deductible)	j HMO contract	~ =	PPO contract	·	I Indemnity contract	
	m	Other (specify)	, <u> </u>		'		ц ,	
9	Ехре	erience-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)		0
	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)		0
		(4) Claims charged				9b(4)		
	C	Remainder of premium: (1) Retention charges (c	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H))	0
		(2) Dividends or retroactive rate refunds. (These	credited.)	9c(2)				
	d	Status of policyholder reserves at end of year: (1	9d(1)					
		(2) Claim reserves	<i>'</i>			9d(2)		
		(3) Other reserves		9d(3)				
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered i	in line 9c(2) .	.)	9e		
10		nexperience-rated contracts:		. , ,	,			
		Total premiums or subscription charges paid to d	arrier			10a	51	182917
	b	If the carrier, service, or other organization incur						
		retention of the contract or policy, other than rep	orted in Part I, line 2 above	, report amo	unt	10b		
	Sp	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	

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

pursuant to ERISA section 103(a)(2).				Inspection			
For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 01/01/2015							
A Name of plan COBALT MORTGAGE, IN	IC. HEALTH 8	WELFARE PLAN		nree-digit an number (PN)	501		
C Plan sponsor's name as shown on line 2a of Form 5500 COBALT MORTGAGE, INC. D Employer Identification Number (Elegannian State of Form 5500) 91-2138037					ber (EIN)		
			Coverage, Fees, and Cos a unit in Parts II and III can be re				
1 Coverage Information:							
(a) Name of insurance ca	rrier						
UNUM LIFE INSURANCI	E COMPANY (OF AMERICA					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		or contract year		
(b) LIIV	code	identification number	policy or contract year	(f) From	(g) To		
01-0278678	62235	579576	1009	01/01/2014	01/01/2015		
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, a	nd other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid					id		
		12481			0		
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all persons)).			
	(a) Name		r, or other person to whom comm	issions or fees were paid			
CONROY, PATRICK J			STEWART STE 602 TTLE, WA 98101				
(b) Amount of sales ar	nd base	Fe	es and other commissions paid				
commissions pa		(c) Amount	(d) Purpose		(e) Organization code		
12481		0					
	(a) Name	and address of the agent, broke	or other person to whom comm	issions or fees were naid			
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(b) Amount of sales ar	nd base	Fe	es and other commissions paid				
commissions pa		(c) Amount	(d) Purp	ose	(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						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

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Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	ridual contract	s with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e		5		
_		tracts With Allocated Funds:				1
	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	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatic	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)	
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	7-(4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(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)			7f	

Schedule A (Form 5500) 2014		Page 4		
Welfare Benefit Contract Infor If more than one contract covers the sar information may be combined for report the entire group of such individual contract.	me group of employees of the sa ing purposes if such contracts are	e experience-rated as	a unit. Where contract	
Benefit and contract type (check all applicable be	oxes)			
Health (other than dental or vision)	b Dental	C Vision		d X Life insurance
■ Temporary disability (accident and sickne	ss) f X Long-term disability	g Suppleme	ental unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k ☐ PPO cont		I Indemnity contract
m X Other (specify) ▶ACCIDENTAL DEATH	· ·	RT TERM DISABILITY		ь .
Ст. Ст. (оростуу	,			
xperience-rated contracts:				
Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but u	npaid	9a(2)		
(3) Increase (decrease) in unearned premiu	m reserve	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 charge	es (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)	•	

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

317204

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.).....

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

9c(1)(F)

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

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor

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 Ccde).

Complete all entries in accordance with

OMB Nos. 1210-0110 1210-0089

2014

FI	Administration	1	ons to the Form 550				
Pension	n Benefit Guaranty Corporation				This Form is Open to Public Inspection		
Part I		ntification Information					
For calen	dar plan year 2014 or fiscal	plan year beginning 01/01/2014	PT-1	and ending 12/31/20			
A This n	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); o						
		x a single-employer plan;	a DFE (specify	y)			
B This re	etum/report is:	the first return/report;	the final return	n/report;			
		x an amended return/report;	a short plan ye	ear return/report (less than	12 months).		
C If the	plan is a collectively-bargain	ed plan, check here		*******			
	k box if filing under:	Form 5558;	automatic exte	ension;	the DFVC program;		
		special extension (enter description	1)				
Part I	Basic Plan Infor	mation—enter all requested information	tion				
1a Nam	e of plan MORTGAGE, INC. HEALT				1b Three-digit plan 501 number (PN) ▶		
	,				1c Effective date of plan 09/14/2001		
	sponsor's name and address MORTGAGE, INC.	ss; include room or suite number (emp	loyer, if for a single-e	employer plan)	2b Employer Identification Number (EIN) 91-2138037		
11241 SLATER AVE NE, SUITE 110 11241 SLATER AVE NE, SUITE 110					2c Plan Sponsor's telephone number 425-605-3100		
KIRKLAND, WA 98033 KIRKLAND, WA 98033 2d Business code (see instructions) 522292							
Caution	: A nenalty for the late or i	ncomplete filing of this return/repor	t will be assessed a	unless reasonable cause	is established		
Under pe	enalties of perjury and other	penalties set forth in the instructions, I as the electronic version of this return	declare that I have	examined this return/report	, including accompanying schedules.		
Y	70	->					
SIGN	1		4.18/16	KEITLI TIP	BLES		
	Signature of plan admini	strator	Date	Enter name of individual	signing as plan administrator		
SIGN	126 €		4.18.16	KEITH TIR	BOLES		
HERE	Signature of employer/pl	an sponsor	Date	Enter name of individual	signing as employer or plan sponsor		
SIGN							
HERE	Signature of DFE		Date	Enter name of individual	planing as DEE		
Preparer		e, if applicable) and address (include r		r) (optional)	Preparer's telephone number (optional)		

3a	Plan administrator's name and address Same as Plan Sponsor		3b Adm	inistrator's EIN		
			3c Admi	inistrator's telephone ber		
4	If the name and/or EIN of the plan sponsor has changed since the last return/rep EIN and the plan number from the last return/report:	ort filed for this plan, enter the name,	4b EIN			
а	Sponsor's name		4c PN			
5	Total number of participants at the beginning of the plan year		5	1026		
6	Number of participants as of the end of the plan year unless otherwise stated (we 6a(2), 6b, 6c, and 6d).	elfare plans complete only lines 6a(1),				
a(1) Total number of active participants at the beginning of the plan year		6a(1)	1026		
a(2	?) Total number of active participants at the end of the plan year		6a(2)	1009		
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	1009		
е	Deceased participants whose beneficiaries are receiving or are entitled to receive	e benefits	. 6e			
f	Total. Add lines 6d and 6e.		. 6f	1009		
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)					
h	Number of participants that terminated employment during the plan year with access than 100% vested		. 6h			
7	Enter the total number of employers obligated to contribute to the plan (only mult	tiemployer plans complete this item)	. 7			
8a b	 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4H 4Q 4D 4R 					
9a		Plan benefit arrangement (check all th	at apply)			
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) X Insurance (2) Code section 412(e)(3)	insurance	contracts		
	(3) Trust	(3) Trust				
	(4) X General assets of the sponsor	(4) General assets of the s	ponsor			
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attac	hed, and, where indicated, enter the num	ber attach	ed. (See instructions)		
а	Pension Schedules	b General Schedules				
	(1) R (Retirement Plan Information)	(1) H (Financial Infor	mation)			
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) I (Financial Inform (3) X 4 A (Insurance Info (4) C (Service Provice	rmation)	,		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) D (DFE/Participa (6) G (Financial Tran	-			