#### 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

2015

This Form is Open to Public Inspection

Part I	Annual Report Ide	entification Information					
For calen	dar plan year 2015 or fisca	al plan year beginning 01/01/2015	_	and ending 12/31/2015			
A This re	eturn/report is for:	a multiemployer plan;		ployer plan (Filers checking this imployer information in accordan			ons); or
		x a single-employer plan;	a DFE (specify	y)			
<b>B</b> This re	eturn/report is:	x the first return/report;	the final return	n/report;			
	•	an amended return/report;	a short plan ye	ear return/report (less than 12 m	onths)	).	
C If the p	olan is a collectively-barga	ined plan, check here				•	
<b>D</b> Check	box if filing under:	Form 5558;	automatic exter	nsion;	the DFVC program;		
		special extension (enter description	n)				
Part II	Basic Plan Info	rmation—enter all requested inform	nation				
1a Name	e of plan	EMPLOYEE WELFARE BENEFIT PLA			1b	Three-digit plan number (PN) ▶	503
					1c	Effective date of pl	an
		r, if for a single-employer plan)	<u> </u>		2b	Employer Identifica	ation
City o	or town, state or province,	apt., suite no. and street, or P.O. Box country, and ZIP or foreign postal coo	) le (if foreign, see instr	ructions)		Number (EIN) 91-0851599	
THE VAN	COUVER CLINIC, INC., P	'S			2c	Plan Sponsor's tele	ephone
						360-397-150	0
700 NE 87			7TH AVE		2d Business code (see		е
VANCOU	VER, WA 98664	VANCOO	VER, WA 98664			instructions) 621111	
Caution:	A penalty for the late or	incomplete filing of this return/repo	ort will be assessed	unless reasonable cause is es	stablis	shed.	
		r penalties set forth in the instructions Il as the electronic version of this retu					
SIGN HERE	Filed with authorized/valid	electronic signature.	05/31/2016	MISTY BENDER			
HEKE	Signature of plan admir	nistrator	Date	Enter name of individual signi	ng as	plan administrator	
SIGN HERE							
TILICE	Signature of employer/p	olan sponsor	Date	Enter name of individual signi	ng as	employer or plan sp	onsor
SIGN HERE							
Danasas	Signature of DFE	and the second s	Date	Enter name of individual signi		DFE telephone number	
Preparer	s name (including firm har	ne, if applicable) and address (include	room or suite numbe	er) Frepa	alei S	telepriorie number	

Form 5500 (2015) Page **2** 

	Plan administrator's name and address Same as Plan Sponsor VANCOUVER CLINIC, INC., PS						ninistrator's EIN 91-0851599
	700 NE 87TH AVE VANCOUVER, WA 98664				num	ninistrator's telephone nber 360-397-1500	
4	If the name and/or EIN of the plan sponsor has changed since the last return EIN and the plan number from the last return/report:	n/report filed f	or this	plan, ente	the name,	<b>4b</b> EIN	
а	Sponsor's name					4c PN	
5	Total number of participants at the beginning of the plan year					5	1118
6	Number of participants as of the end of the plan year unless otherwise stated <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).	d (welfare pla	ns com	nplete only	lines <b>6a(1)</b> ,		
a(	) Total number of active participants at the beginning of the plan year					6a(1)	1118
a(2	?) Total number of active participants at the end of the plan year					6a(2)	1202
b	Retired or separated participants receiving benefits					. 6b	8
С	Other retired or separated participants entitled to future benefits					. 6с	17
d	Subtotal. Add lines 6a(2), 6b, and 6c.					. 6d	1227
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits	S			. 6e	
f	Total. Add lines 6d and 6e					. 6f	1227
g	Number of participants with account balances as of the end of the plan year complete this item)				s 	. 6g	
h	Number of participants that terminated employment during the plan year with less than 100% vested					. 6h	
7	Enter the total number of employers obligated to contribute to the plan (only	multiemploye	er plans	complete	this item)	. 7	
	If the plan provides pension benefits, enter the applicable pension feature could be pension fea	les from the L	List of F	Plan Chara	cteristics Code	s in the ins	
уа	Plan funding arrangement (check all that apply)  (1)	9b Plan b (1)	enefit a	arrangeme Insurand	nt (check all th e	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(2)		Code se	ction 412(e)(3)	insurance	contracts
	(3) Trust (4) X General assets of the sponsor	(3)	¥	Trust	assets of the s	noncor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	(4)	, where				ed. (See instructions)
	Pension Schedules			nedules			,
	(1) R (Retirement Plan Information)	(1)			Financial Infor	mation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) (3) (4)	X	9 A C	Financial Inforr Insurance Info Service Provid	rmation) er Informa	ition)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) (6)			DFE/Participat Financial Tran	-	

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)			
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)				
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)				
enter the R	eceipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report, eceipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure alid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)			

Form 5500 (2015)

Receipt Confirmation Code\_\_

Page 3

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

2015

		pursuant to EF	RISA section 103(a)(2).	Tills FC	Inspection		
For calendar plan year 20	15 or fiscal plan	year beginning 01/01/2015	and e	ending 12/31/2015			
A Name of plan THE VANCOUVER CLINI	C, INC. EMPLO	DYEE WELFARE BENEFIT PLAN	1	ree-digit an number (PN)	503		
C Plan sponsor's name a THE VANCOUVER CLINI		e 2a of Form 5500		D Employer Identification Number (EIN) 91-0851599			
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca UNUM LIFE INSURANCE		AMERICA					
# N = N .	(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		
01-0278678	62235	8461134	573	01/01/2015	12/31/2015		
2 Insurance fee and come descending order of the		ntion. Enter the total fees and total	commissions paid. List in line	3 the agents, brokers, and	other persons in		
(a) Total a	amount of comr	•	(b)	Total amount of fees paid			
		723			0		
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all persons).				
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	ssions or fees were paid			
DISABILITY SPECIALISTS	SINC		W PACIFIC HWY STE 203 OOD, OR 97140				
(b) Amount of sales ar	nd hase	Fees	and other commissions paid				
commissions pa		(c) Amount	(d) Purpo	(e) Organization code			
196		0	0		3		
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	ssions or fees were paid			
BUTLER PARTNERS AND		PO BOX	•				
(b) Amount of color or	nd hasa	Fees	and other commissions paid				
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purpo	se	(e) Organization code		
-1-	527	0	,,,,		3		
For Donomicont Dodinatio	n Ast Nation a	nd OMB Control Numbers and	the instructions for Form FFO	•	1		

Page <b>2 -</b> 1	
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<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
	<del>-</del>	·	
		Fees and other commissions paid	
(b) Amount of sales and base			(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) No	me and address of the agent broke	r or other person to whom commissions or fees were poid	
(a) Na	ine and address of the agent, broke	r, 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	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	4.50
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
confinissions paid	(C) Amount	(u) Fulpose	code
<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(2)			
(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	r, 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
	(-)	727	

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P	art I	Where individual contracts are provided, the entire group of such indiv	idual contracts w	ith each carrier may be treated	d as a unit for purposes of
1	Cur	this report.  Tent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in the general accounts at year e			
_		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		· DO	
		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, check	k here	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separ	ate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation g	juarantee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		, <del>-</del>			
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		<u></u>	
		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) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(4) Other (specify below)	- (4)		
		• Chief (Specify Below)			
		(5) Total deductions			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

	Schedule A (Form 5500) 2015		Pa	nge <b>4</b>		
art I	Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the sa ourposes if such contracts ar	re experien	ce-rated as a unit. Where co	ontracts cover individual empl	
Ber	nefit and contract type (check all applicable boxes	)				
а	Health (other than dental or vision)	<b>b</b> Dental	сГ	Vision	<b>d</b> Life insurance	
е	Temporary disability (accident and sickness)	f Long-term disability	<u> </u>	Supplemental unemployme	ent <b>h</b> Prescription drug	
:				PPO contract	_ 🛱	
•	Stop loss (large deductible)	j  HMO contract	ĸ	PPO contract	I Indemnity contract	CI
m	X Other (specify) ► WORKSITE BENEFITS					
Exp	erience-rated contracts:	_				
а	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpai	id	9a(2)			
	(3) Increase (decrease) in unearned premium re	serve	9a(3)	T.		
	(4) Earned ((1) + (2) - (3))	<u></u>		9a	a(4)	
b	Benefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))			9k	b(3)	
	(4) Claims charged			9k	b(4)	
С	Remainder of premium: (1) Retention charges (	on an accrual basis)				
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies		9c(1)(F)			

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

20042

Part IV **Provision of Information** 11 Did the insurance company fail to provide any information necessary to complete Schedule A?..... Yes 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.....

(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

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

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

2015

nurought to FDICA continu 402(a)(2)					m is Open to Public Inspection		
For calendar plan year 20	15 or fiscal pla	n year beginning 01/01/2015		and end	ling 12/31	/2015	•
A Name of plan THE VANCOUVER CLINI	A Name of plan THE VANCOUVER CLINIC, INC. EMPLOYEE WELFARE BENEFIT F				-digit number (PN)	<b>)</b>	503
C Plan sponsor's name a		ne 2a of Form 5500	1		ver Identificat 851599	tion Number (	(EIN)
on a separat		ning Insurance Contract Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca MODA HEALTH PLANS, If							
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate num persons covered at e			•	ontract year
(0) =	code	identification number	policy or contract y		(f) F	rom	<b>(g)</b> To
93-0438772	54941	10010560	935		01/01/2015		12/31/2015
2 Insurance fee and composite descending order of the		nation. Enter the total fees and to	otal commissions paid. List	in line 3 th	he agents, b	rokers, and o	ther persons in
(a) Total a	amount of com	missions paid		<b>(b)</b> Tot	al amount of	fees paid	
		0					0
3 Persons receiving com	missions and f	fees. (Complete as many entrie	s as needed to report all pe	ersons).			
	(a) Name	and address of the agent, broke	r, or other person to whom	commissio	ons or fees v	vere paid	
(b) Amount of sales ar	nd base	Fe	ees and other commissions	paid			
commissions pa	id	(c) Amount	(d) Purpose				(e) Organization code
	(a) Name a	and address of the agent, broke	r, or other person to whom	commissio	ons or fees w	vere paid	
	(4)	g,	,				
(b) Amount of sales ar	nd base	Fe	ees and other commissions	paid			
commissions pai		(c) Amount	(d	(d) Purpose			(e) Organization code

Page <b>2 -</b> 1	
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<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
	<del>-</del>	·	
		Fees and other commissions paid	
(b) Amount of sales and base			(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) No	me and address of the agent broke	r or other person to whom commissions or foca were poid	
(a) Na	ine and address of the agent, broke	r, 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	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	4.50
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
confinissions paid	(C) Amount	(u) Fulpose	code
<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(2)			
(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	r, 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
	(-)	727	

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P	art I	Where individual contracts are provided, the entire group of such indiv	idual contracts w	ith each carrier may be treated	d as a unit for purposes of
1	Cur	this report.  Tent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in the general accounts at year e			
_		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		· DO	
		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, check	k here	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separ	ate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation g	juarantee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		<del>-</del>			
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		<u></u>	
		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) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(4) Other (specify below)	- (4)		
		• Chief (Specify Below)			
		(5) Total deductions			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

Schedule A (Form 5500) 2015		Page <b>4</b>		
Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the same urposes if such contracts are e	xperience-rated as a	unit. Where contract	
efit and contract type (check all applicable boxes)				
Health (other than dental or vision)	<b>b</b> Dental	<b>c</b> Vision		<b>d</b> Life insurance
Temporary disability (accident and sickness)	f Long-term disability	g Supplemen	tal unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k PPO contra	act	I Indemnity contract
Other (specify)	- Ш	<u> </u>		·
erience-rated contracts:				
Premiums: (1) Amount received	9	a(1)		
(2) Increase (decrease) in amount due but unpai	d 9	a(2)		
(3) Increase (decrease) in unearned premium re-	serve 9	a(3)		
(4) Earned ((1) + (2) - (3))	·		9a(4)	0
Benefit charges (1) Claims paid	9	b(1)	<u>.</u>	
(2) Increase (decrease) in claim reserves	9	b(2)		
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
Remainder of premium: (1) Retention charges (	on an accrual basis)		<u> </u>	
(A) Commissions	-	(1)(A)		
(B) Administrative service or other fees		(1)(B)		

(3) Incurred claims (add (1) and (2)) ...... (4) Claims charged..... Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions..... (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) (H) Total retention ..... 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) ...... 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement...... 9d(1) (2) Claim reserves 9d(2) 9d(3) (3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... 9e **10** Nonexperience-rated contracts: 10a 8136659 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	

Benefit and contract type (check all applicable boxes)

**a** | X | Health (other than dental or vision)

Experience-rated contracts:

Part III

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

<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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2015

This Form is Open to Public Inspection

pursuant to ERISA section 103(a)(2). Inspection							
For calendar plan year 20	15 or fiscal pla	in year beginning 01/01/2015		and en	ding 12/3	1/2015	
A Name of plan THE VANCOUVER CLINIC, INC. EMPLOYEE WELFARE BENEFIT PLAN			_AN		e-digit number (Pl	N) •	503
C Plan sponsor's name a		ne 2a of Form 5500		-	yer Identific 0851599	ation Number (	EIN)
		ning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:	1 Coverage Information:						
(a) Name of insurance ca		RANCE COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
57-0144607	62049	E4374872	53	3	01/01/201	5	12/31/2015
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
25068 13058							
3 Persons receiving com		fees. (Complete as many entrie					
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales a	nd hase	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
						·	
(b) Amount of sales a	nd hase	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code

Page <b>2 -</b> 1	
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P	art I	Where individual contracts are provided, the entire group of such indiv	idual contracts w	ith each carrier may be treated	d as a unit for purposes of
1	Cur	this report.  Tent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in the general accounts at year e			
_		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		· DO	
		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, check	k here	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separ	ate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation g	juarantee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		<del>-</del>			
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		<u></u>	
		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) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(4) Other (specify below)	- (4)		
		• Chief (Specify Below)			
		(5) Total deductions			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

	Schedule A (Form 5500) 2015		Pag	e <b>4</b>	
Part III	Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the sa ourposes if such contracts ar	re experience	e-rated as a unit. Where contract	
Bene	fit and contract type (check all applicable boxes	)			
а	Health (other than dental or vision)	<b>b</b> Dental	с□	Vision	<b>d</b> Life insurance
e	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
m >	Other (specify)    WORKSITE BENEFITS				
Expe	rience-rated contracts:	_			
a F	Premiums: (1) Amount received		9a(1)		
	(2) Increase (decrease) in amount due but unpai	d	9a(2)		
	(3) Increase (decrease) in unearned premium re	serve	9a(3)		
	(4) Earned ((1) + (2) - (3))	<u></u>		9a(4)	
b	Benefit charges (1) Claims paid		9b(1)		
	(2) Increase (decrease) in claim reserves		9b(2)		
	(3) Incurred claims (add (1) and (2))			9b(3)	
	(4) Claims charged			9b(4)	
С	Remainder of premium: (1) Retention charges (	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

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:

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	

(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.....

<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.

OMB No. 1210-0110

2015

nursuant to FDICA coefficient 402(a)(2)			rm is Open to Public Inspection				
For calendar plan year 2015 or fiscal plan year beginning 01/01/2015			and en	nding 12/31/2	015		
A Name of plan THE VANCOUVER CLINIC, INC. EMPLOYEE WELFARE BENEFIT PLAN		AN		e-digit number (PN)	•	503	
C Plan sponsor's name a	IC, INC., PS			91-(	oyer Identificatio 0851599		
		ning Insurance Contract Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca VISION SERVICE PLAN	rrier		(a) Approximate pu	umb or of	T	Policy or o	ontract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a policy or contract	t end of	(f) Fro		ontract year (g) To
06-1227840	53732	12245712	815	•	01/01/2015		12/31/2015
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, bro	kers, and c	other persons in
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid						
0 0							
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees we	re paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	(a) Name	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees we	re paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code

Page <b>2 -</b> 1	
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P	art I	Where individual contracts are provided, the entire group of such indiv	idual contracts w	ith each carrier may be treated	d as a unit for purposes of
1	Cur	this report.  Tent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in the general accounts at year e			
_		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		· DO	
		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, check	k here	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separ	ate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation g	juarantee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		, <del>-</del>			
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		<u></u>	
		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) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(4) Other (specify below)	- (4)		
		• Chief (Specify Below)			
		(5) Total deductions			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

Page <b>4</b>		
<u> </u>	·	

10a

10b

	Schedule A (Form 5500) 2015		Pa	age <b>4</b>		
Part I	Welfare Benefit Contract Information If more than one contract covers the same guinformation may be combined for reporting puthe 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	roup of employees of the surposes if such contracts a	are experien	ce-rated as a unit. Whe	ere contracts	
8 Ben	efit and contract type (check all applicable boxes)					
а	Health (other than dental or vision)	<b>b</b> Dental	c	Vision	d	Life insurance
e	Temporary disability (accident and sickness)	f Long-term disabilit	v g	Supplemental unemp	oloyment <b>h</b>	Prescription drug
i [	Stop loss (large deductible)	i  HMO contract	, s∟ k[	PPO contract	.,	Indemnity contract
' <u> </u>		I I I I I I I I I I I I I I I I I I I	ĸ_	_ FFO contract		Indemnity contract
m	Other (specify)					
0 -	erica e control e control e					
•	erience-rated contracts:	Г	0=(4)		4.40070	
а	Premiums: (1) Amount received		9a(1) 9a(2)		140979	
	(2) Increase (decrease) in amount due but unpair		9a(2) 9a(3)		0	
	(3) Increase (decrease) in unearned premium res					140979
h	(4) Earned ((1) + (2) - (3))	F			9a(4) 111269	140978
b	Benefit charges (1) Claims paid		9b(1)		0	
	(2) Increase (decrease) in claim reserves	<u>-</u>	· · ·			111269
	(3) Incurred claims (add (1) and (2))				9b(3)	111208
•	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (c	, , , , , , , , , , , , , , , , , , ,	00/4\/A\		0	
	(A) Commissions	l l	9c(1)(A)		24671	
	(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)			
	(C) Other specific acquisition costs		9c(1)(D)		0	
	(D) Other expenses	•	9c(1)(E)		0	
	(E) Charges for siele an other continuousies		9c(1)(F)		0	
	(F) Charges for risks or other contingencies. (G) Other retention charges				0	
		-			•	24671
	(H) Total retention	_	_		9c(1)(H)	24071
	(2) Dividends or retroactive rate refunds. (These		LI		9c(2)	0
d	Status of policyholder reserves at end of year: (1	•			9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
<u>e</u>	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in line <b>9c(2</b> )	<b>)</b> .)	9e	<u> </u>
<b>10</b> No	nexperience-rated contracts:					

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

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

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

Specify nature of costs >

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

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

2015

This Form is Open to Public Inspection

pursuant to ERISA section 103(a)(2).				Inspection			
For calendar plan year 2015 or fiscal plan year beginning 01/01/2015				and en	ding 12/3	1/2015	•
A Name of plan THE VANCOUVER CLINI	C, INC. EMPLO	OYEE WELFARE BENEFIT PL	AN	<b>B</b> Three plan	e-digit number (Pl	N) <b>•</b>	503
C Plan sponsor's name a		e 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number (	EIN)
THE VANCOUVER CLINI	C, INC., PS			91-	0851599		
		ing Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
` '	(a) Name of insurance carrier  VILLAMETTE DENTAL INSURANCE, INC						
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
93-1171647	57069	WA195	327	•	01/01/201	5	12/31/2015
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.							
(a) Total amount of commissions paid (b) Total amount of fees paid							
0							
3 Persons receiving com		ees. (Complete as many entrie					
	(a) Name a	nd address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
	(a) Name a	nd address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code

Page <b>2 -</b> 1	
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P	art I	Where individual contracts are provided, the entire group of such indiv	idual contracts w	ith each carrier may be treated	d as a unit for purposes of
1	Cur	this report.  Tent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in the general accounts at year e			
_		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		· DO	
		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, check	k here	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separ	ate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation g	juarantee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		, <del>-</del>			
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		<u></u>	
		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) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(4) Other (specify below)	- (4)		
		• Chief (Specify Below)			
		(5) Total deductions			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

Pa	ge <b>4</b>		
kperien (	er(s) or members of the same er ce-rated as a unit. Where contra init for purposes of this report.		
c [ g [ k [	Vision Supplemental unemployment PPO contract	d [ h [ I [	Life insurance Prescription drug Indemnity contract
·/4\	20550	17	

Pa	art III	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr					
		information may be combined for reporting put the entire group of such individual contracts with the entire					cover individual employees,
8	Bene	ofit and contract type (check all applicable boxes)	•				
	а	Health (other than dental or vision)	<b>b</b> X Dental	с	Vision		d Life insurance
	е	<u>'</u>	f Long-term disabil	ity <b>g</b>	⊒ ¬	lovment I	h Prescription drug
	: -		<b>=</b>	·		noymont i	
	'	Stop loss (large deductible)	j  HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Evno	rience-rated contracts:					
9	-//0	Premiums: (1) Amount received		9a(1)		225527	
		(2) Increase (decrease) in amount due but unpaid		· · ·		0	
		(3) Increase (decrease) in amount due but unpaid				0	
		(4) Earned ((1) + (2) - (3))				9a(4)	225527
	_	Benefit charges (1) Claims paid				175746	
		(2) Increase (decrease) in claim reserves		:-:		0	
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	175746
		(4) Claims charged				9b(4)	175746
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)		•		
		(A) Commissions		9c(1)(A)		0	
		(B) Administrative service or other fees				20297	
		(C) Other specific acquisition costs		9c(1)(C)		0	
		(D) Other expenses				0	
		(E) Taxes				6089	
		(F) Charges for risks or other contingencies				0	
		(G) Other retention charges				0	
		(H) Total retention	_	_		9c(1)(H)	26386
		(2) Dividends or retroactive rate refunds. (These	_			9c(2)	0
		Status of policyholder reserves at end of year: (1				9d(1)	0
		(2) Claim reserves				9d(2)	0
		(3) Other reserves				9d(3)	0
4.0		Dividends or retroactive rate refunds due. (Do no	ot include amount entere	d in line <b>9c(2)</b>	.)	9e	0
10		nexperience-rated contracts:	*			40-	
	_	Total premiums or subscription charges paid to d				10a	
		If the carrier, service, or other organization incurretention of the contract or policy, other than repo	, .		•	10b	
	Spe	ecify nature of costs					

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

Schedule A (Form 5500) 2015

<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

2015

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 20°	15 or fiscal pla	an year beginning 01/01/2015		and en	ding 12/3	31/2015	•
A Name of plan				<b>B</b> Three-digit			
THE VANCOUVER CLINI	C, INC. EMPI	LOYEE WELFARE BENEFIT PLA	AN plan number (PN) 503			503	
				Pian		,	
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number (	EIN)
THE VANCOUVER CLINI	C, INC., PS			91-	0851599		
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance car		RANCE COMPANY					
	T				T		
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or co	ntract year
(D) EIN	code	identification number	policy or contrac		(f)	From	<b>(g)</b> To
57-0144607	62049	E4368528	248		01/01/201	5	12/31/2015
2 Insurance fee and commodescending order of the		nation. Enter the total fees and to	tal commissions paid. L	st in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of con	nmissions paid		<b>(b)</b> To	otal amount	of fees paid	
		77050					39811
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name	and address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
(h) Amount of colon on	d boos	Fe	es and other commission	ns paid			
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purpose				(e) Organization code
commissione par	~	(c) / mileant		( <del>u)</del> : u.poo.			(c) organization occo
		<u> </u>					
	(a) Name	and address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
			es and other commission	ne poid			
(b) Amount of sales an				•	•		(a) Onnoning (in a set
commissions pai	α	(c) Amount		(d) Purpose	е		(e) Organization code

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P	art I	Where individual contracts are provided, the entire group of such indiv	idual contracts w	ith each carrier may be treated	d as a unit for purposes of
1	Cur	this report.  Tent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in the general accounts at year e			
_		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		· DO	
		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, check	k here	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separ	ate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation g	juarantee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		, <del>-</del>			
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		<u></u>	
		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) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(4) Other (specify below)	- (4)		
		• Chief (Specify Below)			
		(5) Total deductions			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

	Oshari I. A. /Fara 5500) 0045		D 4		
	Schedule A (Form 5500) 2015		Page <b>4</b>		
rt I	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting p the entire group of such individual contracts of	roup of employees of the sa urposes if such contracts ar	e experience-rated	as a unit. Where contract	
Ben	nefit and contract type (check all applicable boxes)				
а	Health (other than dental or vision)	<b>b</b> Dental	<b>c</b> Vision		<b>d</b> Life insurance
е	Temporary disability (accident and sickness)	f Long-term disability	g 🗌 Supple	emental unemployment	h Prescription drug
i [	Stop loss (large deductible)	j HMO contract	k ☐ PPO c	ontract	I Indemnity contract
m		<i>-</i> Ц			
Ехр	erience-rated contracts:				
a ์	Premiums: (1) Amount received		9a(1)		
	(2) Increase (decrease) in amount due but unpaid	j	9a(2)		
	(3) Increase (decrease) in unearned premium res	serve	9a(3)		
	(4) Earned ((1) + (2) - (3))			9a(4)	
b	Benefit charges (1) Claims paid		9b(1)		
	(2) Increase (decrease) in claim reserves		9b(2)		
	(3) Incurred claims (add (1) and (2))			9b(3)	
	(4) Claims charged			9b(4)	
С	Remainder of premium: (1) Retention charges (c	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)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

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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:

Part III

(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 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)(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

For calendar plan year 2015 or fiscal plan year beginning

### **Insurance Information**

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

File as an attachment to Form 5500.

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

and ending

12/31/2015

01/01/2015

OMB No. 1210-0110

2015

This Form is Open to Public Inspection

v. 150123

THE VANCOUVER CLINI	OYEE WELFARE BENEFIT PLA	AN		e-digit number (PN)	•	503	
•	C Plan sponsor's name as shown on line 2a of Form 5500 THE VANCOUVER CLINIC, INC., PS						EIN)
		ing Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca THE LINCOLN NATIONAL		NCE COMPANY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a		Po	licy or co	ntract year
(b) LIN	code	identification number	policy or contract		(f) From		<b>(g)</b> To
35-0472300	65676	000010183458	1202	!	01/01/2015		12/31/2015
2 Insurance fee and composite descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents, broker	s, and ot	her persons in
(a) Total a	amount of comr	nissions paid		<b>(b)</b> To	otal amount of fees	paid	
0 992							992
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker			ions or fees were	paid	
THE PARTNERS GROUP			SW 68TH PKWY, STE 2 LAND, OR 97223	200			
<b>(b)</b> Amount of sales ar	nd hase	Fe	es and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose				(e) Organization code
	0	992 B	ROKER BONUS				3
	(a) Name a	nd address of the agent, broker	or other person to who	m commiss	ions or fees were i	 paid	
	(a) Name a	na dadrese of the agent, broker	, or ourse person to who	11 0011111100	ions of reco were	<u> </u>	
(b) Amount of sales and base			es and other commission				
commissions pa	d	(c) Amount		(d) Purpos	e		(e) Organization code
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, se	e the instructions for F	orm 5500.		Sched	lule A (Form 5500) 2015

Page <b>2 -</b> 1	
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P	art I	Where individual contracts are provided, the entire group of such indiv	idual contracts w	ith each carrier may be treated	d as a unit for purposes of
1	Cur	this report.  Tent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in the general accounts at year e			
_		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		· DO	
		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, check	k here	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separ	ate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation g	juarantee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		, <del>-</del>			
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		<u></u>	
		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) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(4) Other (specify below)	- (4)		
		• Chief (Specify Below)			
		(5) Total deductions			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

		Schedule A (Form 5500) 2015			Paç	ge <b>4</b>		
Pa	art III	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts we	oup our	ses if such contracts ar	e experienc	e-rated as a unit. Who	ere contrac	
8	Benef	it and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b	Dental	С	Vision		<b>d</b> X Life insurance
	е 🗍	Temporary disability (accident and sickness)	f	Long-term disability	g	Supplemental unemp	oloyment	h Prescription drug
	iΠ	Stop loss (large deductible)	ιĒ	HMO contract	k 🗌			I Indemnity contract
	m X		אפום	_	ш			
		Other (specify) PAOOIDENTAL DEATT AND	DION	WEWBERWEIT				
9	Experi	ence-rated contracts:						
_	•	remiums: (1) Amount received			9a(1)			
		2) Increase (decrease) in amount due but unpaid			9a(2)			
	(3	B) Increase (decrease) in unearned premium res	erve.		9a(3)			
	(4	4) Earned ( <b>(1) + (2) - (3)</b> )					9a(4)	
	b E	Benefit charges (1) Claims paid			9b(1)			
	(2	2) Increase (decrease) in claim reserves			9b(2)			
	(3	B) Incurred claims (add <b>(1)</b> and <b>(2)</b> )					9b(3)	
	(4	4) Claims charged					9b(4)	
	<b>C</b> F	Remainder of premium: (1) Retention charges (o	n an	· · · · · · · · · · · · · · · · · · ·				
		(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

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Part IV	Provision of Information			
11 Did the	e 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.....

(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

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2015 or fiscal plan year beginning

### **Insurance Information**

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

File as an attachment to Form 5500.

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

01/01/2015

and ending

12/31/2015

OMB No. 1210-0110

2015

This Form is Open to Public Inspection

A Name of plan THE VANCOUVER CLINIC, INC. EMPLOYEE WELFARE BENEFIT PLAN				B Three-digit plan number (PN) 503			
				'	,		
C Plan sponsor's name as shown on line 2a of Form 5500 THE VANCOUVER CLINIC, INC., PS				D Employer Identification Number (EIN) 91-0851599			
		ing Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca THE LINCOLN NATIONAL		NCE COMPANY					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		Policy or o	contract year	
(b) LIN	code	identification number	policy or contract		(f) From	<b>(g)</b> To	
35-0472300	65676	000010183459	1202		01/01/2015	12/31/2015	
2 Insurance fee and composite descending order of the		tion. Enter the total fees and tot	al commissions paid. Li	st in line 3	the agents, brokers, and	other persons in	
(a) Total a	amount of comn	•		(b) Total amount of fees paid			
		0				2500	
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all p	persons).			
THE DARTHERS SPOUR	(a) Name a	nd address of the agent, broker,			ions or fees were paid		
THE PARTNERS GROUP		PORTI	SW 68TH PKWY, STE 2 LAND, OR 97223	200			
(b) Amount of sales ar	nd base	Fee	es and other commissions paid				
commissions pa	id	(c) Amount			e	(e) Organization code	
0 2500			ROKER BONUS			3	
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	ions or fees were paid		
(b) Amount of sales and base Fees and other commissions p			ns paid		_		
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	e the instructions for F	orm 5500.		5500) 0045	

Page <b>2 -</b> 1	
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P	art I	Where individual contracts are provided, the entire group of such indivi	dual contracts	with each carrier may be treated	d as a unit for purposes of
1	Cur	this report.  Tent value of plan's interest under this contract in the general account at year of the second secon	and	4	
		rent value of plan's interest under this contract in the general accounts at year en			
_		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		. 00	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, che	ck here	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in sep	arate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee	
		(3) guaranteed investment (4) other			
		_			
	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			
		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) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(4)		
		(4) Other (specify below)	, , , , ,		
	_	(5) Total deductions			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

Schedule A (Form 5500) 2015		Pa	nge <b>4</b>		
Welfare Benefit Contract Informat If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the sar urposes if such contracts are	e experienc	ce-rated as a unit. Whe	ere contrac	
efit and contract type (check all applicable boxes)	ı				
Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
Temporary disability (accident and sickness)	f X Long-term disability	g	Supplemental unemp	oloyment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
Other (specify)	- 🗖		•		_
erience-rated contracts:	_				
Premiums: (1) Amount received	<u> </u>	9a(1)			
(2) Increase (decrease) in amount due but unpai	d	9a(2)			
(3) Increase (decrease) in unearned premium res	serve	9a(3)	_		
(4) Earned ((1) + (2) - (3))				9a(4)	0
Benefit charges (1) Claims paid		9b(1)	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		9c(1)(A)			
(B) Administrative service or other fees		9c(1)(B)			
(C) Other specific acquisition costs		9c(1)(C)	<del>_</del>		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

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10b

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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:

Benefit and contract type (check all applicable boxes)

a Health (other than dental or vision)

Experience-rated contracts:

Part III

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.) ......

(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 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)

<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

For calendar plan year 2015 or fiscal plan year beginning

### **Insurance Information**

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

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

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

01/01/2015

and ending

12/31/2015

OMB No. 1210-0110

2015

This Form is Open to Public Inspection

A Name of plan THE VANCOUVER CLINIC, INC. EMPLOYEE WELFARE BENEFIT PLAN				B Three-digit plan number (PN) 503			
					, ,		
C Plan sponsor's name as shown on line 2a of Form 5500 THE VANCOUVER CLINIC, INC., PS				D Employer Identification Number (EIN) 91-0851599			
		ing Insurance Contract ( Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca THE LINCOLN NATIONAL		NCE COMPANY					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		Policy or o	contract year	
(b) EIN	code	identification number	policy or contract		(f) From	<b>(g)</b> To	
35-0472300	65676	000010183460	330		01/01/2015	12/31/2015	
2 Insurance fee and composite descending order of the		tion. Enter the total fees and tot	al commissions paid. Lis	st in line 3	the agents, brokers, and	other persons in	
(a) Total a	amount of comn	nissions paid		(b) Total amount of fees paid			
0 1056					1056		
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all p	ersons).			
	(a) Name a	nd address of the agent, broker,			ions or fees were paid		
THE PARTNERS GROUP		11740 PORTL	SW 68TH PKWY, STE 2 AND, OR 97223	00			
(b) Amount of sales ar	nd base	Fee	es and other commissions paid				
commissions pa	id	(c) Amount			e	(e) Organization code	
0 1056 B			ROKER BONUS			3	
	(a) Name a	nd address of the agent, broker,	or other person to whom	n commiss	ions or fees were paid		
(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	e the instructions for Fo	orm 5500.	-		

Page <b>2 -</b> 1	
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<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid				
	<del>-</del>	·				
(b) Amount of sales and base Fees and other commissions paid						
(b) Amount of sales and base			(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) No	me and address of the agent broke	r or other person to whom commissions or fees were poid				
(a) Na	ine and address of the agent, broke	r, 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	r, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	4.50			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
confinissions paid	(C) Amount	(u) Fulpose	code			
<b>(a)</b> Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid				
(2)						
(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	r, 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			
	(-)	727				

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P	art I	Where individual contracts are provided, the entire group of such indiv	idual contracts w	ith each carrier may be treated	d as a unit for purposes of
1	Cur	this report.  Tent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in the general accounts at year e			
_		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		· DO	
		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, check	k here	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separ	ate accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation g	juarantee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		<del>-</del>			
	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			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		<u></u>	
		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) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(4) Other (specify below)	<b>-</b> (4)		
		• Chief (Specify Below)			
		(5) Total deductions			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

Schedule A (Form 5500) 2015		Page <b>4</b>		
Irt III Welfare Benefit Contract Inform If more than one contract covers the same information may be combined for reporting the entire group of such individual contract	e group of employees of the sa g purposes if such contracts ar	re experience-rated as	a unit. Where contra	
Benefit and contract type (check all applicable box	es)			
a Health (other than dental or vision)	<b>b</b> Dental	<b>C</b> Vision		<b>d</b> X Life insurance
e Temporary disability (accident and sickness	s) <b>f</b> Long-term disability	g ☐ Supplem	ental unemployment	h Prescription drug
i Stop loss (large deductible)	j HMO contract	k ☐ PPO cor		I Indemnity contract
m ☐ Other (specify) ▶	• 🗅	Ш		<b>Ц</b> ,
Experience-rated contracts:				
a Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but un	paid	9a(2)		
(3) Increase (decrease) in unearned premium	reserve	9a(3)		
(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)	
<b>c</b> Remainder of premium: (1) Retention charges	s (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

99987

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:

Part III

(D) Other expenses 9c(1)(D)

(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......

(E) Taxes.....

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

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

9c(1)(E)

9c(1)(F)

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

Colonial Life & Accident Insurance Company Post Office Box 1365 Columbia, SC 29202-1365



Vancouver Clinic Attn: Sheri Mcelravy 700 Ne 87th Ave Suite 370 Vancouver, WA 98664

April 15, 2016

Re: Information Schedule A (Form 5500)

BCN: E4368528

Dear Sheri Mcelravy:

Colonial Life & Accident Insurance Company is pleased to certify the enclosed Schedule A information on your Colonial Life insurance products.

This Schedule A information is forwarded to you for use by your Plan Administrator in completing your annual report Form 5500 if your company is required to file this form. Colonial Life takes no position as to whether or not your insurance program constitutes a "Welfare Benefit Plan" under the ERISA Act of 1974. The enclosed report shows producer compensation information, including earned commissions and bonuses. Bonuses and non cash incentives are reported as "Amount of Fees Paid, If Any." The report also contains premium paid information and the approximate number of covered persons.

Colonial Life's premium paid information may differ from your records due to timing of posting payments, timing of employee payroll changes, and our internal business practices related to the application of premium. For this reason we suggest you use premium information from your records for reporting "Premium Paid to Carrier."

For more information on reporting requirements or assistance in completing the Form 5500, call the EFAST helpline at 1-866-463-3278. The form and additional information can also be accessed at www.efast.dol.gov. Consult your company attorney or other advisors if you have any questions regarding your obligation to file a Form 5500. For questions regarding the enclosed information, please contact Service Operations at 1-800-256-7004, option 1.

We appreciate this opportunity to serve you.

Sincerely,

Service Operations Department

### Insurance Data for Schedule A Form 5500

# AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 THE COMPENSATION DATA IS PROVIDED TO COMPLY WITH VARIOUS REGULATIONS, REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

Name of Carrier: Colonial Life & Accident Insurance Company

Post Office Box 1365 Columbia, SC 29202-1365

**Carrier EIN:** 57-0144607 **Carrier NAIC Code:** 62049

Account Name: Vancouver Clinic

**Billing Control Number:** E4368528

**Plan Year Date Range:** 01/01/2015 - 12/31/2015

Organization Code For Agents/Producers: 3

Amount for Pre-tax or Employer Paid Premium: \$0.00
Amount for After Tax Paid Premium: \$188,760.52
Total Paid Premium: \$188,760.52

APPROXIMATE NUMBER OF PERSONS COVERED AT END OF PLAN YEAR: 248

Insurance Fees a	nd Commission Inform	nation for Schedule	A Form 5500	
Agent/Producer Name Address	Amount of Commissions On Pre-Tax Or Employer Paid Policies	Or Employee	Total Commissions Paid	Amount of Fees Paid If Any
Heartsease Llc 1521 Ne 63rd Ave Hillsboro OR 97124	\$0.00	\$2,142.58	\$2,142.58	\$1,551.76
Premier Worksite Solutions Inc 806 Nw 79th St Vancouver WA 98665	\$0.00	\$27,671.61	\$27,671.61	\$31,467.22
Benefits By Design Inc 2101 Ne 279th St Ridgefield WA 98642	\$0.00	\$7,393.48	\$7,393.48	\$3,935.39
Mark J Robison 1255 Kienas Road Kalispell MT 59901	\$0.00	\$6,381.97	\$6,381.97	\$193.56

Page 3 of 4 Vancouver Clinic E4368528

Agent/Producer Name Address	Amount of Commissions On Pre-Tax Or Employer Paid Policies	Amount of Commissions On After Tax Or Employee Paid Policies	Total Commissions Paid	Amount of Fees Paid If Any	
Susan J Leach 4419 Ne 131st Place Portland OR 97230	\$0.00	\$972.37	\$972.37	\$151.53	
Michael Fleming 11681 Sw Teal Blvd Beaverton OR 97007	\$0.00	\$669.72	\$669.72	\$1.82	ı
Karen Clay Kunkler 1709 Nw 45th Avenue Camas WA 98607	\$0.00	\$3,757.16	\$3,757.16	\$662.95	
Roxana Buschman 400 Northeast 149th Street Vancouver WA 98685	\$0.00	\$5,186.25	\$5,186.25	\$755.45	
Christine Lynn Morgester 9405 Ne 100th Way Vancouver WA 98662	\$0.00	\$4,317.83	\$4,317.83	\$907.23	
Derek Thurston 112 Nw 114th St Vancouver WA 98685	\$0.00	\$4,478.21	\$4,478.21	\$184.27	
Kerr-Cruickshank Inc 11740 Sw 68th Pkwy Portland OR 97223	\$0.00	\$14,078.83	\$14,078.83	\$0.00	
Grand Totals	\$0.00	\$77,050.01	\$77,050.01	\$39,811.18	

## **Certification Statement**

Colonial Life & Accident Insurance Company hereby certifies that the enclosed statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate.

L. Michael Miller

Vice President of Sales Comp, Incentives & Support

Page 4 of 4 Vancouver Clinic E4368528

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Colonial Life & Accident Insurance Company Post Office Box 1365 Columbia, SC 29202-1365



Vancouver Clinic - Monthly Attn: Sheri Mcelravy 700 Ne 87th Ave Suite 370 Vancouver, WA 98664

April 15, 2016

Re: Information Schedule A (Form 5500)

BCN: E4374872

Dear Sheri Mcelravy:

Colonial Life & Accident Insurance Company is pleased to certify the enclosed Schedule A information on your Colonial Life insurance products.

This Schedule A information is forwarded to you for use by your Plan Administrator in completing your annual report Form 5500 if your company is required to file this form. Colonial Life takes no position as to whether or not your insurance program constitutes a "Welfare Benefit Plan" under the ERISA Act of 1974. The enclosed report shows producer compensation information, including earned commissions and bonuses. Bonuses and non cash incentives are reported as "Amount of Fees Paid, If Any." The report also contains premium paid information and the approximate number of covered persons.

Colonial Life's premium paid information may differ from your records due to timing of posting payments, timing of employee payroll changes, and our internal business practices related to the application of premium. For this reason we suggest you use premium information from your records for reporting "Premium Paid to Carrier."

For more information on reporting requirements or assistance in completing the Form 5500, call the EFAST helpline at 1-866-463-3278. The form and additional information can also be accessed at www.efast.dol.gov. Consult your company attorney or other advisors if you have any questions regarding your obligation to file a Form 5500. For questions regarding the enclosed information, please contact Service Operations at 1-800-256-7004, option 1.

We appreciate this opportunity to serve you.

Sincerely,

Service Operations Department

### Insurance Data for Schedule A Form 5500

# AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 THE COMPENSATION DATA IS PROVIDED TO COMPLY WITH VARIOUS REGULATIONS, REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

Name of Carrier: Colonial Life & Accident Insurance Company

Post Office Box 1365 Columbia, SC 29202-1365

**Carrier EIN:** 57-0144607 **Carrier NAIC Code:** 62049

Account Name: Vancouver Clinic - Monthly

**Billing Control Number:** E4374872

**Plan Year Date Range:** 01/01/2015 - 12/31/2015

Organization Code For Agents/Producers: 3

Amount for Pre-tax or Employer Paid Premium: \$0.00
Amount for After Tax Paid Premium: \$62,177.50
Total Paid Premium: \$62,177.50

APPROXIMATE NUMBER OF PERSONS COVERED AT END OF PLAN YEAR: 53

Insurance Fees a	nd Commission Inform	nation for Schedule	A Form 5500	
Agent/Producer Name Address	Amount of Commissions On Pre-Tax Or Employer Paid Policies		Total Commissions Paid	Amount of Fees Paid If Any
Heartsease Llc 1521 Ne 63rd Ave Hillsboro OR 97124	\$0.00	\$705.93	\$705.93	\$510.73
Premier Worksite Solutions Inc 806 Nw 79th St Vancouver WA 98665	\$0.00	\$8,896.31	\$8,896.31	\$10,116.15
Benefits By Design Inc 2101 Ne 279th St Ridgefield WA 98642	\$0.00	\$2,491.77	\$2,491.77	\$1,326.31
Margaret Bryant 18014 Sw Belmore Ave Lake Oswego OR 97035	\$0.00	\$1.56	\$1.56	\$0.00

Page 3 of 4 Vancouver Clinic - Monthly E4374872

Agent/Producer Name Address	Amount of Commissions On Pre-Tax Or Employer Paid Policies	Amount of Commissions On After Tax Or Employee Paid Policies	Total Commissions Paid	Amount of Fees Paid If Any
Mark J Robison 1255 Kienas Road Kalispell MT 59901	\$0.00	\$1,744.48	\$1,744.48	\$52.90
Susan J Leach 4419 Ne 131st Place Portland OR 97230	\$0.00	\$160.71	\$160.71	\$25.04
Michael Fleming 11681 Sw Teal Blvd Beaverton OR 97007	\$0.00	\$270.60	\$270.60	\$0.73
Karen Clay Kunkler 1709 Nw 45th Avenue Camas WA 98607	\$0.00	\$1,422.16	\$1,422.16	\$250.71
Roxana Buschman 400 Northeast 149th Street Vancouver WA 98685	\$0.00	\$2,070.05	\$2,070.05	\$301.53
Christine Lynn Morgester 9405 Ne 100th Way Vancouver WA 98662	\$0.00	\$2,141.30	\$2,141.30	\$449.91
Derek Thurston 112 Nw 114th St Vancouver WA 98685	\$0.00	\$588.28	\$588.28	\$24.20
Benefit Resources Inc 4000 Se International Way Portland OR 97222	\$0.00	\$1.59	\$1.59	\$0.00
Kerr-Cruickshank Inc 11740 Sw 68th Pkwy Portland OR 97223	\$0.00	\$4,572.94	\$4,572.94	\$0.00
Grand Totals	\$0.00	\$25,067.68	\$25,067.68	\$13,058.21

## **Certification Statement**

Colonial Life & Accident Insurance Company hereby certifies that the enclosed statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate.

| A. Wich Mills

L. Michael Miller

Vice President of Sales Comp, Incentives & Support

Page 4 of 4 Vancouver Clinic - Monthly E4374872

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#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Part I Annual Report Identification Information
For calendar plan year 2015 or fiscal plan year beginning 01/01/2015

# 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

2015

This Form is Open to Public Inspection

and ending 12/31/2015

A This return	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 (specify				
B This return.	/report is:	the first return/report;	the final return	/report;			
	·	an amended return/report;	a short plan ye	ear return/report (less than	12 months).		
C If the plan i	is a collectively-bargain	ned plan, check here			▶□		
D Check box	if filing under:	Form 5558;	automatic exter	nsion;	the DFVC program;		
		special extension (enter description	)				
Part II		mation—enter all requested informa	ation				
<b>1a</b> Name of p		MPLOYEE WELFARE BENEFIT PLA	N		<b>1b</b> Three-digit plan number (PN) ▶	503	
					1c Effective date of pl 11/01/1983	an	
2a Plan sponsor's name (employer, if for a single-employer plan)2b EmployerMailing address (include room, apt., suite no. and street, or P.O. Box)NumbCity or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)91-08						ation	
THE VANCOU	VER CLINIC, INC., PS	S			2c Plan Sponsor's tele number 360-397-150	•	
700 NE 87TH A VANCOUVER,		700 NE 87 VANCOUV	TH AVE 'ER, WA 98664		2d Business code (seinstructions) 621111		
Caution: A pe	enalty for the late or in	ncomplete filing of this return/repor	t will be assessed :	uniess reasonable cause i	is established.		
Under penaltie	s 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 sche	dules,	
5875	-0					,	
SIGN	8		5-27-16	Shen N	1cElrary		
HERE Sign	nature of plan admini	strator	Date	Enter name of individual s	ual signing as plan administrator		
SIGN	9		5-27-16	Shen M	ICELIANI		
HERE   Sign	nature of employer/pl	an sponsor	Date	Enter name of individual s	onsor		
SIGN HERE							
Signature of DFE Date Enter name of individual					signing as DFE		
Preparer's name (including firm name, if applicable) and address (include room or suite number)  Preparer's tele					reparer's telephone number		
		ce and OMR Control Numbers see			Form \$500		

	Form 5500 (2015)		Pa	ge <b>2</b>	!					
	The second secon		·							
	Plan administrator's name and address Same as Plan Sponsor E VANCOUVER CLINIC, INC., PS				<del></del>			1	ninistrator's EIN 91-0851599	<del></del>
70	D NE 87TH AVE NCOUVER, WA 98664							nun	ninistrator's teleph nber 360-397-1500	one
									1.1	
4	If the name and/or EIN of the plan sponsor has changed since the last return, EIN and the plan number from the last return/report:	/герог	t filed fo	r this	plan, er	nter the n	ame,	4b EIN		
а	Sponsor's name							4c PN		
5	Total number of participants at the beginning of the plan year							5		1118
6	Number of participants as of the end of the plan year unless otherwise stated <b>6a(2), 6b, 6c,</b> and <b>6d)</b> .	(well	are plan	s cor	nplete o	nly lines (	6a(1),	:		
a(	1) Total number of active participants at the beginning of the plan year			•••••				6a(1)		1118
a(	2) Total number of active participants at the end of the plan year	•••••				•••••••	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	6a(2)		1202
b	Retired or separated participants receiving benefits							6b		8
¢	Other retired or separated participants entitled to future benefits				•••••	•••••		6c		17
d	Subtotal. Add lines 6a(2), 6b, and 6c.		***********					6d		1227
e	Deceased participants whose beneficiaries are receiving or are entitled to rec	eive l	enefits.				•••••	6e		
f	Total. Add lines 6d and 6e							6f		1227
g	Number of participants with account balances as of the end of the plan year (complete this item)							6g		
h	Number of participants that terminated employment during the plan year with less than 100% vested							6h		
7	Enter the total number of employers obligated to contribute to the plan (only n						<del></del>	7		· · · · · · · · · · · · · · · · · · ·
	If the plan provides pension benefits, enter the applicable pension feature code.  If the plan provides welfare benefits, enter the applicable welfare feature code.  4A 4D 4E 4Q 4B 4H									
	Plan funding arrangement (check all that apply)  (1)		(1) (2) (3) (4)	X	Insura Code Trust Gener	section 4	12(e)(3) i of the sp	nsurance onsor	contracts ed. (See instruction	ons)
	Pension Schedules (1) R (Retirement Plan Information)		Genera (1)		nedules	l (Financ				

(2)

(3)

(4)

(5)

(6)

1 (Financial Information - Small Plan)

D (DFE/Participating Plan Information)

**G** (Financial Transaction Schedules)

C (Service Provider Information)

9 A (Insurance Information)

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

(2)

(3)

actuary

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
<b>11a</b> If the pla 2520.10	an provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 1-2.)
If "Yes"	is checked, complete lines 11b and 11c.
11b is the pi	an currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)
11c Enter the	e Receipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report, e Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure

Page 3

Form 5500 (2015)