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		entification Information					
For cale	ndar plan year 2015 or fisca	al plan year beginning 01/01/2015	_	and ending 12/31/2015			
A This	return/report is for:	a multiemployer plan;		oloyer plan (Filers checking this mployer information in accordan			ons); or
		x a single-employer plan;	a DFE (specify	<u> </u>			
B This	eturn/report is:	the first return/report;	the final return	/report;			
		an amended return/report;	a short plan ye	ear return/report (less than 12 m	onths).	
C If the	plan is a collectively-bargai	ned plan, check here				>	
D Chec	k box if filing under:	Form 5558;	automatic exter	nsion;	th	e DFVC program;	
		special extension (enter description	n)		_		
Part	Basic Plan Info	rmation—enter all requested inform	nation				
	ne of plan				1b	Three-digit plan	504
MEDIC	AL, DENTAL AND VISION	PLAN				number (PN) ▶	501
					1c	Effective date of pl 03/01/1988	lan
		r, if for a single-employer plan) apt., suite no. and street, or P.O. Box)		2b	Employer Identifica Number (EIN)	ation
City	City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)					91-0545118	
DUNN LUMBER COMPANY				2c	Plan Sponsor's tel- number 206-632-213		
PO BOX 45550 3801 LATONA AVENUE NE SEATTLE, WA 98145 SEATTLE, WA 98105			2d	Business code (se instructions) 444130	e		
		incomplete filing of this return/repo					
		r penalties set forth in the instructions, Il as the electronic version of this retur					
SIGN HERE	Filed with authorized/valid	electronic signature.	07/20/2016	RACHEL SILVA			
	Signature of plan admin	istrator	Date	Enter name of individual sign	ing as	plan administrator	
SIGN							
HERE	Signature of employer/p	alan snonsor	Date	Enter name of individual sign	ina as	employer or plan sr	oonsor
	Olgitatare of ompreyor,p	van openeer	Date	Emor name of marriadar orgin	ii ig ao	omployer of plant of	2011001
SIGN							
HERE	Signature of DFE		Date	Enter name of individual sign	ina ac	DEE	
Preparei		ne, if applicable) and address (include				telephone number	
i i	, ,	, ,		,			

Form 5500 (2015) Page **2**

3a	Plan administrator's name and address Same as Plan Sponsor		3b Admin	istrator's EIN
			3c Admin	istrator's telephone er
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:	/report filed for this plan, enter the name,	4b EIN	
а	Sponsor's name		4c PN	
5	Total number of participants at the beginning of the plan year		5	261
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d).	d (welfare plans complete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year		6a(1)	261
a(2	Total number of active participants at the end of the plan year		6a(2)	320
b	Retired or separated participants receiving benefits		6b	0
С	Other retired or separated participants entitled to future benefits		6c	0
d	Subtotal. Add lines 6a(2), 6b, and 6c.		6d	320
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits	6e	
f	Total. Add lines 6d and 6e		. 6f	
g	Number of participants with account balances as of the end of the plan year complete this item)		. 6g	
h	Number of participants that terminated employment during the plan year with less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only	multiemployer plans complete this item)	. 7	
b	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan at the plan provides welfare benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan	les from the List of Plan Characteristics Code	s in the instr	
9a	Plan funding arrangement (check all that apply) (1)	9b Plan benefit arrangement (check all the (1)	insurance c	ontracts
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	ttached, and, where indicated, enter the num	ber attached	I. (See instructions)
а	Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) H (Financial Inform (2) I (Financial Inform (3) X 3 A (Insurance Inform (4) C (Sontial Provide	mation – Smarmation)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(4) C (Service Provide (5) D (DFE/Participati (6) G (Financial Trans	ing Plan Info	ormation)

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

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2015

			ERISA section 103(a)(2).	e imormati	This For	m is Open to Public Inspection
For calendar plan year 20°	15 or fiscal plai	n year beginning 01/01/2015		and end	ding 12/31/2015	
A Name of plan MEDICAL, DENTAL AND	VISION PLAN			B Three plan	e-digit number (PN)	501
C Plan sponsor's name a DUNN LUMBER COMPAI	NY			91-0	yer Identification Number 0545118	
on a separat		ning Insurance Contract Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance ca LIFEMAP ASSURANCE CO					9."	
(b) EIN			persons covered at policy or contract	end of	(f) From	ontract year (g) To
93-6030398	97985	WA05287W	290	year	01/01/2015	12/31/2015
2 Insurance fee and composition descending order of the		ation. Enter the total fees and to	otal commissions paid. Lis	st in line 3 t	the agents, brokers, and c	ther persons in
(a) Total a	amount of com	missions paid		(b) Tot	tal amount of fees paid	
, ,		1039		, ,	·	0
3 Persons receiving com	missions and fo	ees. (Complete as many entrie	es as needed to report all p	ersons).		
<u> </u>	(a) Name a	and address of the agent, broke	er, or other person to whom	n commissi	ons or fees were paid	
BROWN AND BROWN OF	WASHINGTO		FOURTH AVENUE, SUIT TLE, WA 98101	E 2400		
(b) Amount of sales ar	nd base	Fe	ees and other commission	s paid		
commissions pai		(c) Amount	((d) Purpose		
1039					3	
	(a) Name a	and address of the agent, broke	er, or other person to whom	n commissi	ons or fees were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission			
commissions pai		(c) Amount	(d) Purpose)	(e) Organization code

Page 2 - 1	
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(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
	-	·	
		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 food 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
•	•	, , ,	
(a) 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
(a) 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
(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		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 ▶			
		-			
	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 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)	- (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	ge 4	<u> </u>		
art III	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting porting the entire group of such individual contracts of	oup o	es if such contracts a	re experienc	e-rated as a unit. Whe	re contrac		
Benef	fit and contract type (check all applicable boxes)							
а	Health (other than dental or vision)	b	Dental	С	Vision		d X	Life insurance
e 🗍	Temporary disability (accident and sickness)	f	Long-term disability	, g	Supplemental unempl	oyment	h	Prescription drug
i ∏	Stop loss (large deductible)	iΠ	HMO contract	k	PPO contract		ıĒ	Indemnity contract
m X		_						,
	Other (specify) Proofile Introduction	DIOIV	EMBERMENT					
Exper	ience-rated contracts:							
•	remiums: (1) Amount received			9a(1)				
(:	2) Increase (decrease) in amount due but unpaid	it		9a(2)				
(;	3) Increase (decrease) in unearned premium res	erve		9a(3)				
(-	4) Earned ((1) + (2) - (3))		-			9a(4)		
b i	Benefit charges (1) Claims paid			9b(1)				
(2	2) Increase (decrease) in claim reserves			9b(2)				
(:	3) Incurred claims (add (1) and (2))		-			9b(3)		
(4	4) Claims charged					9b(4)		
C	Remainder of premium: (1) Retention charges (o	n an a	accrual basis)		_			
	(A) Commissions			9c(1)(A)				
	(B) Administrative service or other fees			9c(1)(B)				
	(C) Other specific acquisition costs		T T	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)				

9c(1)(H)

9c(2)

9d(1)

9d(2)

9d(3)

9e

10a

10b

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

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2015

pursuant to E			re required to provide the informa RISA section 103(a)(2).		This Form is Open to Public Inspection		
For calendar plan year 20	15 or fiscal pla	n year beginning 01/01/2015	and er	nding 12/31/2015			
A Name of plan MEDICAL, DENTAL AND	VISION PLAN	ı		e-digit n number (PN)	501		
C Plan sponsor's name a		e 2a of Form 5500	•	oyer Identification Nu- 0545118	umber (EIN)		
		ning Insurance Contract Condition Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca		CANADA					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		cy or contract year		
(D) LIN	code	identification number	policy or contract year	(f) From	(g) To		
38-1082080	80802	10079	101	01/01/2015	12/31/2015		
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	Il commissions paid. List in line 3	the agents, brokers	, and other persons in		
	amount of com	missions paid	(b) T	otal amount of fees p	paid		
		2660	• •		0		
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all persons).				
	(a) Name a	and address of the agent, broker,	or other person to whom commiss	sions or fees were pa	aid		
BROWN AND BROWN OF	F WASHINGTO	N, INC. 1501 FC SEATTI	DURTH AVENUE, SUITE 2400 .E, WA 98101				
		Foo	s and other commissions paid				
(b) Amount of sales an commissions pa		(c) Amount	(d) Purpos	(e) Organization code			
2660		(a) : u.peo		3			
	(a) Nama a	and address of the agent, broker,	or other person to whom commiss	sions or foos wore no	nid		
	(a) Name a	and address of the agent, broker,	or other person to whom commiss	sions of fees were pa	alu		
(b) Amount of sales a	nd bass	Fee	s and other commissions paid				
commissions pa		(c) Amount	(d) Purpos	е	(e) Organization code		
	A (N) ()						

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(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
	-	·	
		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
•	•	, , ,	
(a) 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
(a) 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
(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		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 ▶			
		-			
	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 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)	- (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	e 4	
rt l	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such contracts the entire group of such individual contracts with each carrier may be	s are experience	-rated as a unit. Where contract	
Ber	nefit 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 X Long-term disab	ility g	Supplemental unemployment	h Prescription drug
i	Stop loss (large deductible) j	_ =	PPO contract	I Indemnity contract
m		ш		□ ,
•••				
Ехр	perience-rated contracts:			
a	Premiums: (1) Amount received	9a(1)		
	(2) Increase (decrease) in amount due but unpaid	9a(2)		
	(3) Increase (decrease) in unearned premium reserve	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 (on an accrual basis)			
	(A) Commissions			
	(B) Administrative service or other fees			
	(C) Other specific acquisition costs			
	(D) Other expenses	9c(1)(D)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

19103

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

(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)(E)

9c(1)(F)

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

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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	n year beginning 01/01/2015		and en	ding 12/3	1/2015	
A Name of plan MEDICAL, DENTAL AND	VISION PLAN			B Three plan	e-digit number (PN	N) •	501
C Plan sponsor's name a DUNN LUMBER COMPAI		e 2a of Form 5500			yer Identific 0545118	ation Number (EIN)
		ning Insurance Contract Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
	(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	(g) To
91-1272766	00000	00	320)	01/01/201	5	12/31/2015
2 Insurance fee and communication 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 a	amount of com			(b) To	otal amount	of fees paid	
		0					0
3 Persons receiving com		ees. (Complete as many entrie					
	(a) Name a	and 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	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code
	(a) Name a	and 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	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code

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Schedule A (Form 5500) 2015 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions paid (b) Amount of sales and base (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 Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions paid (b) Amount of sales and base (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 Fees and other commissions paid (b) Amount of sales and base (e) Organization commissions paid (c) Amount (d) Purpose 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 ▶			
		-			
	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 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)	- (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 4	
art II	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 urposes if such contracts	s are experience	rated as a unit. Where contract	
Bene	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 disabi	lity \mathbf{g}	Supplemental unemployment	h Prescription drug
ιĒ	Stop loss (large deductible)	i HMO contract	- =	PPO contract	I Indemnity contract
m	Other (specify) EMPLOYEE ASSISTANCE	· 🗀			☐
··· <u>/</u>	Other (specify) FEMILECTEE ASSISTANCE	TROOKAW			
Expe	rience-rated contracts:				
	Premiums: (1) Amount received		9a(1)		
	(2) Increase (decrease) in amount due but unpai	d	9a(2)		
	(3) Increase (decrease) in unearned premium re-	serve	9a(3)		
	(4) Earned ((1) + (2) - (3))		<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				
	(B) Administrative service or other fees				
	(C) Other specific acquisition costs				
	(D) Other expenses				
	(E) Taxes		. 9c(1)(E)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

7069

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

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

9c(1)(F)

(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

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

		501 Januarion
er plan (Filers checking to over information in accor- ort; eturn/report (less than 1	this box must attach a list of ordance with the form instruction of the property of the DFVC program; 1b Three-digit plan number (PN) 1c Effective date of program of the property of the pro	501 Januarion
oyer information in accordance ort; eturn/report (less than 1	12 months). 1b Three-digit plan number (PN) ▶ 1c Effective date of p 03/01/1988 2b Employer Identific Number (EIN) 91-0545118 2c Plan Sponsor's te number (206) 632-2 2d Business code (se instructions)	501 Januarion
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mined this return/report	t, including accompanying sch	edules,
Rachel Sil	lva	
nter name of individual	l signing as plan administrator	-
¥		
nter name of individual	I signing as employer or plan s	ponsor
nter name of individual	I signing as DFE Prenarer's telephone number	
	mined this return/report of my knowledge and leading to the Rachel State of individual inter name of individual inter name of individual inter name of individual inter name of individual	ess reasonable cause is established. mined this return/report, including accompanying sch of my knowledge and belief, it is true, correct, and co Rachel Sulva inter name of individual signing as plan administrator inter name of individual signing as employer or plan signing as plan administrator inter name of individual signing as DFE Preparer's telephone number

3a	Plan administrator's name and address Same as Plan Sponsor						Bb Administrator's EIN	
							3c Administrator's telephone number	
4	If the name and/or EIN of the plan sponsor has changed since the last return/report EIN and the plan number from the last return/report:			ort filed for this plan, enter the name,			4b EIN	
а	100 M	Sponsor's name			4c PN			
5	Total number	r of participants at the beginning of the plan year				5	300	
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	a(1) Total number of active participants at the beginning of the plan year						273	
a(2	2) Total numi	per of active participants at the end of the plan year				6a(2)	261	
b	Retired or separated participants receiving benefits					6b	0	
С	Other retired	Other retired or separated participants entitled to future benefits				. 6c	0	
d	Subtotal. Add	d lines 6a(2), 6b, and 6c				. 6d	261	
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits							
f	Total. Add lines 6d and 6e.					. 6f		
g	Number of p complete this	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 accrued benefits that were less than 100% vested					6h		
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)					. 7		
b	If the plan pr	ovides pension benefits, enter the applicable pension feature ∞ ovides welfare benefits, enter the applicable welfare feature ∞ $4\mathrm{D}$ $4\mathrm{E}$ $4\mathrm{H}$ $4\mathrm{L}$ $4\mathrm{Q}$	les from the	List of	Plan Characteristics Code	es in the i		
9a		arrangement (check all that apply) Insurance	9b Plan I	penefit	arrangement (check all th Insurance	nat apply)		
	(1) X (2)	Code section 412(e)(3) insurance contracts	(2)	Ĥ	Code section 412(e)(3)	insuranc	e contracts	
	(3)	Trust	(3)	Д	Trust			
40	(4)	General assets of the sponsor	(4)	X	General assets of the s		hed (See instructions)	
10	Check all ap	plicable boxes in 10a and 10b to indicate which schedules are a				inder allal	Aica. (Gee mandonolis)	
a		Pension Schedules b General Schedules (1) R (Retirement Plan Information) (4) H (Financial Inform						
	(1)		(1)	П	H (Financial Infor	- E	- "F" \	
	(2)	MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(2)	Н	I (Financial Information 3 A (Insurance Info		Small Plan)	
		actuary	(3) (4)	×	C (Service Provide		ation)	
	(3)	SB (Single-Employer Defined Benefit Plan Actuarial	(5)	Н	D (DFE/Participal		and the second second second	
	. П	Information) - signed by the plan actuary	(6)	Ĭ	G (Financial Tran	saction S	chedules)	
4Q	Represer	nts Employee Assistance Program.	nemi Service de la companya de la co		* - 4			

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	Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)				
73	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.) Yes No 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				