### 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

# 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 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

2016

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016				and ending 12/31/2016			
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.)				
		x a single-employer plan	a DFE (specif		nuance wit	in the form manacho	ліз.)
D This		the first return/report	the final return				
<b>D</b> Inis	return/report is:	an amended return/report		ear return/report (less than 1	12 months)	<b>\</b>	
<b>O</b> 16 11				. ,	•		
C If the	C If the plan is a collectively-bargained plan, check here						
<b>D</b> Chec	k box if filing under:	Form 5558	automatic exte	ension	the	e DFVC program	
		special extension (enter description	<u> </u>				
Part I		nation—enter all requested information	on		1		
	ne of plan H & LIFE PLAN FOR EMPL	OYEES OF MILLIMAN, INC.			1b	Three-digit plan number (PN) ▶	501
					1c	Effective date of pl 05/01/1986	lan
		r, if for a single-employer plan) apt., suite no. and street, or P.O. Box)			2b	Employer Identifica Number (EIN)	ation
		country, and ZIP or foreign postal code		ructions)		91-0675641	
MILLIMA	N, INC.				2c	Plan Sponsor's tele	ephone
						number 206-624-7940	)
1201 ET	J AVE STE 2000	1201 ETU	AVE STE 3800		2d	Business code (se	
	H AVE STE 3800 E, WA 98101	SEATTLE	, WA 98101			instructions) 541990	
Caution	: A penalty for the late or	incomplete filing of this return/repo	rt will be assessed	unless reasonable cause	is establis	shed.	
		r penalties set forth in the instructions,					
stateme	nts and attachments, as we	Il as the electronic version of this retur	n/report, and to the I	pest of my knowledge and be	elief, it is tr	rue, correct, and con	mplete.
SIGN HERE	Filed with authorized/valid	electronic signature.	07/26/2017	WILLIAM PEDERSEN			
	Signature of plan admir	nistrator	Date	Enter name of individual	signing as	plan administrator	
SIGN HERE							
TILICE	Signature of employer/p	olan sponsor	Date	Enter name of individual	signing as	employer or plan sp	onsor
SIGN HERE	Filed with authorized/valid	electronic signature.	07/27/2017	BRENDA MUELLER			
Signature of DFE Date Enter name of individual sign					signing as	DFE	
Preparer's name (including firm name, if applicable) and address (include room or suite number)				Preparer's	telephone number		
JENNIE SKIDMORE						206-624-7940	
MILLIMAN, INC.						200 024 7540	
	FTH AVENUE						
CLATTI	, .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	SEATTLE, WA 98101					

Form 5500 (2016) Page **2** 

	Plan administrator's name and address Same as Plan Sponsor  MILLIMAN'S EMPLOYEE BENEFIT COMMITTEE					<b>3b</b> Administrator's EIN 91-0675641		
	1 5TH AVE STE 3800 ATTLE, WA 98101					ministrator's telephone mber 206-624-7940		
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 for	this p	plan, enter the name,	<b>4b</b> EII	N		
а	Sponsor's name				4c PN	1		
5	Total number of participants at the beginning of the plan year				5	2503		
6	Number of participants as of the end of the plan year unless otherwise states 6a(2), 6b, 6c, and 6d).	d (welfare plans	s com	plete only lines 6a(1),		2505		
a(1	) Total number of active participants at the beginning of the plan year				6a(1)	2503		
a(2	Total number of active participants at the end of the plan year				6a(2)	2633		
b	Retired or separated participants receiving benefits				6b	100		
С	Other retired or separated participants entitled to future benefits				6c			
d	Subtotal. Add lines 6a(2), 6b, and 6c		•••••		6d	2733		
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefits			6e			
f	Total. Add lines <b>6d</b> and <b>6e</b>				6f	2733		
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 p	plans	complete this item)	7			
	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 provides welfare benefits, enter the applicable welfare feature could be plan funding errangement (check all that apply)	des from the Lis	st of P	lan Characteristics Codes	s in the in			
9a	Plan funding arrangement (check all that apply)  (1)	(1)	nent a	arrangement (check all tha Insurance	at apply)			
	Code section 412(e)(3) insurance contracts	(2)		Code section 412(e)(3)	insuranc	e contracts		
	(3) Trust	(3)	Ц	Trust				
10	(4) General assets of the sponsor  Check all applicable boxes in 10a and 10b to indicate which schedules are a	(4)	here	General assets of the spindicated, enter the numb		hed (See instructions)		
					or attack	ned. (Occ mondonono)		
а	Pension Schedules (1) R (Retirement Plan Information)	b Genera (1)	II Sch	edules  H (Financial Inform	nation)			
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) (3) (4)	X	I (Financial Inform  11 A (Insurance Infor  C (Service Provide	mation)	,		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) (6)		D (DFE/Participati G (Financial Trans	-			

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
	plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR .101-2.)
If "Ye	es" is checked, complete lines 11b and 11c.
<b>11b</b> Is the	e plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)
Rece	the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the ipt 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 lipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)
Rece	eipt Confirmation Code

Form 5500 (2016)

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

2016

pursuant to ERISA section 103(a)(2).				Inspection		
For calendar plan yea	r 2016 or fiscal plar	n year beginning 01/01/2016	and e	ending 12/31	/2016	
A Name of plan HEALTH & LIFE PLAN	N FOR EMPLOYEE	ES OF MILLIMAN, INC.		ee-digit n number (PN	) •	501
C Plan sponsor's name as shown on line 2a of Form 5500  MILLIMAN, INC.  D Employer Identification Number 91-0675641					ation Number (	EIN)
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.					
1 Coverage Informati	on:					
(a) Name of insuranc				_		
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		Policy or co	ontract year
(b) LII1	code	identification number	policy or contract year	(f)	From	<b>(g)</b> To
23-7089668	53031	30022174	1685	01/01/2016		12/31/2016
2 Insurance fee and descending order o		ation. Enter the total fees and total	I commissions paid. List in line	3 the agents, b	orokers, and o	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
3 Persons receiving	commissions and fe	ees. (Complete as many entries a	as needed to report all persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	sions or fees	were paid	
(b) Amount of sale	es and base	Fees	and other commissions paid			
commission	s paid	(c) Amount	(d) Purpose			(e) Organization code
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	sions or fees	were paid	
		_	·		·	
(b) Amount of sale	es and base	Fees	and other commissions paid			
commissions		(c) Amount	<b>(d)</b> Purpo	se		(e) Organization code
For Bonne 1 D 1	ada Ad N. d	and the Instructions for Form 55				hulo A (Form 5500) 2016

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1			
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid			
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	Organization code		
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid			
	_				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid			

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:			<u> </u>	
	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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	ane	۵ ۵

Part III Welfare Benefit Contract Information  If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s),					
	the information may be combined for reporting purposes if such contr employees, the entire group of such individual contracts with each ca				
8	Benefit and contract type (check all applicable boxes)				
	a ☐ Health (other than dental or vision) b ☐ Dental	С	Vision	C	Life insurance
	e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability		Supplemental unem	ployment <b>h</b>	Prescription drug
	i ☐ Stop loss (large deductible) j ☐ HMO contract		PPO contract		I  Indemnity contract
	m Other (specify)	L			<u> </u>
	The Carlet (Specify)				
9	Experience-rated contracts:				
	a Premiums: (1) Amount received	9a(1)		209384	
	(2) Increase (decrease) in amount due but unpaid	9a(2)		200001	
	(3) Increase (decrease) in unearned premium reserve	9a(3)			
	(4) Earned ((1) + (2) - (3))			9a(4)	209384
	<b>b</b> Benefit charges (1) Claims paid	9b(1)		, , ,	
	(2) Increase (decrease) in claim reserves				
	(3) Incurred claims (add (1) and (2))			9b(3)	
	(4) Claims charged			9b(4)	
	C Remainder of premium: (1) Retention charges (on an accrual basis)				
	(A) Commissions	9c(1)(A)			
	(B) Administrative service or other fees	9c(1)(B)			
	(C) Other specific acquisition costs	9c(1)(C)			
	(D) Other expenses	9c(1)(D)			
	(E) Taxes	9c(1)(E)			
	(F) Charges for risks or other contingencies	9c(1)(F)			
	(G) Other retention charges	9c(1)(G)			
	(H) Total retention			9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These amounts were paid in	cash, or	credited.)	9c(2)	
	<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide to	benefits afte	r retirement	9d(1)	
	(2) Claim reserves			9d(2)	
	(3) Other reserves			9d(3)	
	e Dividends or retroactive rate refunds due. (Do not include amount entered	in line 9c(2	<b>)</b> .)	9e	
10	Nonexperience-rated contracts:				
	a Total premiums or subscription charges paid to carrier			10a	
	<b>b</b> If the carrier, service, or other organization incurred any specific costs in co	onnection wi	th the acquisition or		
	retention of the contract or policy, other than reported in Part I, line 2 above	e, report am	ount	10b	
	Specify nature of costs.				
D.	art IV Provision of Information				
	Did the insurance company fail to provide any information necessary to comple	ete Schedul	e A?	Yes	No
12	If the answer to line 11 is "Yes," specify the information not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

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

OMB No. 1210-0110

2016

		pursuant to	ERISA section 103(a)(2)	).			Inspection
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016							
A Name of plan HEALTH & LIFE PLAN	FOR EMPLOYE	ES OF MILLIMAN, INC.			e-digit number (PN	N) <b>•</b>	501
C Plan sponsor's name as shown on line 2a of Form 5500  MILLIMAN, INC.  D Employer Identification Number (E 91-0675641					EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information	n:						
(a) Name of insurance		ANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
41-0417830	66168	32905-G	2633		01/01/2016	5	12/31/2016
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							
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).							
3 Persons receiving c							
	(a) Name	and address of the agent, broke	a, or other person to who	III COIIIIIISS	ions or rees	were paid	
(b) Amount of sales	and base	F	ees and other commission	ns paid			
commissions	paid	(c) Amount	(d) Purpose			(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	s and base	F	ees and other commission	ns paid			
commissions		(c) Amount		(d) Purpose	e		(e) Organization code

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1			
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid			
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	Organization code		
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid			
	_				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid			

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	art	II Investment and Annuity Contract Information				
Where individual contracts are provided, the entire group of such individual this report.		idual contrac	ets with each carrier may	be treated	as a unit for purposes of	
4	Curr	ent value of plan's interest under this contract in the general account at year		4		
_		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:			<u> </u>	
	а					
	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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	ane	۵ ۵

Pa	art II						
		If more than one contract covers the same group of employ the information may be combined for reporting purposes if employees, the entire group of such individual contracts with	such contracts are exp	erience-rated as a uni	t. Where con	tracts	s cover individual
8	Bene	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision) <b>b</b> Dental	С	Vision	(	x k	Life insurance
	е 🗆		m disability <b>g</b>	Supplemental unem		_	Prescription drug
	i H	Stop loss (large deductible)	- 5	PPO contract	, -,		Indemnity contract
	m	Other (specify)	T. L.			- ⊔	machinity contract
	m _	Other (specify)					
9	Evnor	erience-rated contracts:					
_		Premiums: (1) Amount received	9a(1)				
		(2) Increase (decrease) in amount due but unpaid				ł	
	•	(3) Increase (decrease) in unearned premium reserve					
	•	(4) Earned ((1) + (2) - (3))		<u> </u>	9a(4)		
	_ `	Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves	21.72				
	,	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )			9b(3)		
		(4) Claims charged			9b(4)		
	C	Remainder of premium: (1) Retention charges (on an accrual ba	sis)				
		(A) Commissions	9c(1)(A)				
		(B) Administrative service or other fees	9c(1)(B)				
		(C) Other specific acquisition costs					
		(D) Other expenses					
		(E) Taxes					
		(F) Charges for risks or other contingencies	0 (4)(0)				
		(G) Other retention charges			0 (4)(1)		
		(H) Total retention			9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These amounts were			9c(2)		
		Status of policyholder reserves at end of year: (1) Amount held to	•		9d(1)		
		(2) Claim reserves			9d(2)		
		(3) Other reserves			9d(3)		
10		Dividends or retroactive rate refunds due. (Do not include amou	nt entered in line 9C(2)	).)	9e		
10		nexperience-rated contracts:  Total premiums or subscription charges paid to carrier			10a		1000420
					100		1000420
		If the carrier, service, or other organization incurred any specific retention of the contract or policy, other than reported in Part I, lin			10b		
		cify nature of costs.	= asoro, roport a			1	
Pa	art I\	V Provision of Information					
11	Did	the insurance company fail to provide any information necessary	to complete Schedule	e A?	Yes	No	)
12	If th	he 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

2016

		pursuant to	ERISA section 103(a)(2)				Inspection	
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and						1/2016		
A Name of plan HEALTH & LIFE PLAN FO	OR EMPLOYE	ES OF MILLIMAN, INC.			e-digit number (PN	N) <b>•</b>	501	
C Plan sponsor's name a MILLIMAN, INC.	as shown on lin	e 2a of Form 5500		-	oyer Identific 0675641	ation Number (	EIN)	
		rning Insurance Contract. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca		3						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	contract year	
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To	
36-1236610	70670	H56675	33		01/01/2016	6	12/31/2016	
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								
3 Damana masabidan asar		(Commission or many anti-						
3 Persons receiving com		ees. (Complete as many entrie						
	(a) Name a	and address of the agent, broke	i, of other person to who	II COITIITISS	ions or rees	were paiu		
(b) Amount of sales a	nd base	F	ees and other commission	ns paid				
commissions pa	id	(c) Amount		(d) Purpose	е		(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		
	(4)		,,					
(h) Amount of sales a	(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount	(d) Purpose				(e) Organization code	

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	art	II Investment and Annuity Contract Information				
Where individual contracts are provided, the entire group of such individual this report.		idual contrac	ets with each carrier may	be treated	as a unit for purposes of	
4	Curr	ent value of plan's interest under this contract in the general account at year		4		
_		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:			<u> </u>	
	а					
	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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	ane	۵ ۵

Pa	ırt II	III Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individua	roup of employees of the ng purposes if such cont	racts are expe	erience-rated as a unit	. Where co	ontracts cover i	
<b>8</b> E	3ene	efit and contract type (check all applicable boxes)						
;	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insu	ırance
	e 🗀	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Supplemental unem	oloyment	h Prescrip	tion drug
i	:	Stop loss (large deductible)	j X HMO contract	· - <u>-</u>	PPO contract	,	- =	ty contract
	m [	Other (specify)	, M. Filvio contract	~ _	117 0 0011111101		· 🗌 macmin	.y oonaaot
9 E	xpe	erience-rated contracts:						
	a P	Premiums: (1) Amount received		9a(1)				
	(	(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese						
	(	(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		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)			_	
		(F) Charges for risks or other contingencies		9c(1)(F)			_	
		(G) Other retention charges				0. (4)(1)		
		(H) Total retention	_	_		9c(1)(H)	)	
		(2) Dividends or retroactive rate refunds. (These a				9c(2)		
		Status of policyholder reserves at end of year: (1)	•			9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
40		Dividends or retroactive rate refunds due. (Do not	include amount entered	d in line <b>9c(2)</b> .	.)	9e		
10		nexperience-rated contracts:				40		
		Total premiums or subscription charges paid to ca				10a		531509
		If the carrier, service, or other organization incurre				106		
,		retention of the contract or policy, other than reporecify nature of costs.	ted in Part I, line 2 abov	e, report amo	ount	10b		
Pa	rt I	IV Provision of Information						
11	Did	d the insurance company fail to provide any informa	ation necessary to comp	ete Schedule	A?	Yes	No	<del></del>
		he answer to line 11 is "Yes," specify the informatio			<u>—</u>			

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

2016

This Form is Open to Public

pursuant to ERISA section 103(a)(2).				Inspection					
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and en						1/2016	-		
A Name of plan HEALTH & LIFE PLAN FO	S OF MILLIMAN, INC.		B Three	e-digit number (PN	N) <b>•</b>	501			
C Plan sponsor's name a MILLIMAN, INC.	s shown on line	e 2a of Form 5500			oyer Identific 0675641	ation Number (	EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance ca		F COLORADO							
	(c) NAIC	(d) Contract or	(e) Approximate nur			Policy or co	contract year		
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To		
84-0591617	95669	5473	23		01/01/2016	6	12/31/2016		
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. Lis	st in line 3	the agents,	brokers, and ot	her persons in		
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount	of fees paid			
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all p	ersons).					
	(a) Name a	nd address of the agent, broker, or	or other person to whom	commiss	ions or fees	were paid			
(b) Amount of sales ar	nd base	Fees	s and other commissions	s paid					
commissions pa		(c) Amount	(0	(d) Purpose		(e) Organization code			
	(a) Name a	nd address of the agent, broker,	or other person to whom	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		

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:			<u> </u>	
	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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	ane	۵ ۵

Pa	rt II	Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individua	roup of employees of the	racts are expe	erience-rated as a unit	. Where co	ontracts cover in	
<b>8</b> E	3ene	efit and contract type (check all applicable boxes)						
;	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insur	ance
	е 🗀	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Supplemental unem	oloyment	h Prescript	on drug
i	ı 📙	Stop loss (large deductible)	j X HMO contract	· - <u>-</u>	PPO contract	,	I  Indemnity	-
	m [	Other (specify)	Time contract		1 1 0 contract			Communication
9 E	xper	erience-rated contracts:						
	а. Р	Premiums: (1) Amount received		9a(1)				
	(	(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese						
	(	(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		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)			_	
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention	······	<u></u>		9c(1)(H)	)	
		(2) Dividends or retroactive rate refunds. (These a	amounts were paid ir	n cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	d in line <b>9c(2)</b> .	.)	9e		
10	Non	nexperience-rated contracts:				_		
	a ·	Total premiums or subscription charges paid to ca	rrier			10a		319793
		If the carrier, service, or other organization incurre						
		retention of the contract or policy, other than repor	ted in Part I, line 2 abov	e, report amo	ount	10b		
	500	cify nature of costs.						
Pa	rt I\	V Provision of Information						
11	Did	the insurance company fail to provide any informa	tion necessary to comp	lete Schedule	A?	Yes	No	
12	If th	ne answer to line 11 is "Yes," specify the informatio	n 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

2016

			pursuant to	ERISA Section 103(a)(2)	١.			Inspection
For calendar	plan year 20	16 or fiscal pla	n year beginning 01/01/2016		and en	ding 12/3	1/2016	•
A Name of p		OR EMPLOYE	ES OF MILLIMAN, INC.			e-digit number (Pl	N) •	501
C Plan spon		s shown on lin	e 2a of Form 5500		-	oyer Identific 0675641	ation Number (	EIN)
Part I			rning Insurance Contract. Individual contracts grouped					
1 Coverage	Information:							
(a) Name of i			TH PLAN INC.					
		(c) NAIC	(d) Contract or	(e) Approximate n	umber of		Policy or co	ntract year
(b) E	EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
14-1641028		95491	10005562	10	1	01/01/2016	6	12/31/2016
		mission information	ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid								
3 Persons re	eceiving 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) Amou	nt of sales ar	nd base	F	ees and other commissio	ns paid			
	missions pai		(c) Amount		(d) Purpos	е		(e) Organization code
		(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
							·	
(b) Amou	nt of sales ar	nd base	F	ees and other commissio	ns paid			
	missions pai		(c) Amount	(d) Purpose				(e) Organization code

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:			<u> </u>	
	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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa,			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	ane	۵ ۵

Pa	art II							
		If more than one contract covers the same group of the information may be combined for reporting purp employees, the entire group of such individual cont	oses if such contr	acts are expe	erience-rated as a uni	t. Where con	tract	s cover individual
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	Dental	с	Vision		d 🗌	Life insurance
	е □		ong-term disabilit		Supplemental unem	plovment	n⊟	Prescription drug
	. □		HMO contract		PPO contract	,	브	Indemnity contract
			IIVIO CONTIACT	□	11 O contract		•⊔	macrimity contract
	m _	Other (specify)						
0 1								
	•	erience-rated contracts:	Γ	00(1)			<u> </u>	
		Premiums: (1) Amount received(2) Increase (decrease) in amount due but unpaid		9a(1) 9a(2)			1	
	•	(3) Increase (decrease) in amount due but unpaid		9a(2)			1	
	•	(4) Earned ((1) + (2) - (3))	_			9a(4)		
	_ `	Benefit charges (1) Claims paid	Г	9b(1)		<u>, ou(+)</u>		
		(2) Increase (decrease) in claim reserves		9b(2)			1	
	,	(3) Incurred claims (add (1) and (2))	L			9b(3)		
		(4) Claims charged				9b(4)		
	,	Remainder of premium: (1) Retention charges (on an acc						
		(A) Commissions	(	9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)			Ī	
		(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)			<u> </u>	
		(G) Other retention charges		9c(1)(G)		T		
		(H) Total retention	_	_		9c(1)(H)		
	(	(2) Dividends or retroactive rate refunds. (These amoun	ts were paid in	cash, or	credited.)	9c(2)		
	d :	Status of policyholder reserves at end of year: (1) Amount	nt held to provide b	penefits after	retirement	9d(1)		
	(	(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
40		Dividends or retroactive rate refunds due. (Do not include the control of the con	e amount entered	in line 9c(2).	)	9e		
10		nexperience-rated contracts:				40-		400700
		Total premiums or subscription charges paid to carrier				10a		120789
		If the carrier, service, or other organization incurred any retention of the contract or policy, other than reported in	•		•	10b		
		cify nature of costs.	i ait i, iiile z above	s, report arrio	unt	100		
Pa	art I\	V Provision of Information						
11	Did	the insurance company fail to provide any information ne	ecessary to comple	ete Schedule	A?	Yes	No	)
12	If th	he answer to line 11 is "Yes," specify the information not p	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

2016

pursuant to ERISA section 103(a)(2).					Inspection			
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and er					ding 12/3	1/2016		
A Name of plan HEALTH & LIFE PLAN FO	OR EMPLOYE	ES OF MILLIMAN, INC.			e-digit number (Pl	N) •	501	
C Plan sponsor's name a MILLIMAN, INC.	as shown on lin	e 2a of Form 5500		_	oyer Identific 0675641	ation Number (	EIN)	
		rning Insurance Contract. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca LIFEWISE ASSURANCE C								
	(c) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or co	ntract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To	
91-1161450	94188	WA-518288 9999	2219	1	01/01/2016	6	12/31/2016	
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
3 Persons receiving com		ees. (Complete as many entrie	•		. ,	.,		
	(a) Name a	and address of the agent, broke	e, or other person to who	m commiss	ions of fees	were pala		
(b) Amount of sales ar	nd base		ees and other commission	ns paid				
commissions pa	id	(c) Amount	(d) Purpose			(e) Organization code		
	(a) Name a	and address of the agent, broke	er, 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 pa		(c) Amount		(d) Purpose			(e) Organization code	

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:			<u> </u>	
	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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	ane	Δ

Pa	art I	III Welfare Benefit Contract Information	ion					
		If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	g purposes if such cont	racts are expe	erience-rated as a un	t. Where co	ntracts cover in	
8	Bene	efit and contract type (check all applicable boxes)						
	аΓ	Health (other than dental or vision)	<b>b</b> Dental	с□	Vision		<b>d</b> Life insu	rance
	е		f  Long-term disabili		Supplemental unem	nlovment	h Prescrip	tion drug
	· [	Stop loss (large deductible)	j ☐ HMO contract		PPO contract	picymoni		ty contract
	• <u>′</u>		I I I I I I I I I I I I I I I I I I I	□	11 O contract			y contract
	m [	Other (specify)						
9 1	Evno	erience-rated contracts:						
-	•	Premiums: (1) Amount received		9a(1)			┥	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			╡	
		(3) Increase (decrease) in unearned premium rese		9a(3)			<del>- </del>	
		(4) Earned ((1) + (2) - (3))				9a(4)		
	_	Benefit charges (1) Claims paid				.,		
		(2) Increase (decrease) in claim reserves		(-)			1	
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		
		(4) Claims charged				9b(4)		
		Remainder of premium: (1) Retention charges (on						
		(A) Commissions		9c(1)(A)			7	
		(B) Administrative service or other fees		9c(1)(B)			7	
		(C) Other specific acquisition costs		9c(1)(C)			7	
		(D) Other expenses		9c(1)(D)			1	
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	d in line <b>9c(2)</b> .	)	9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to ca	rrier			10a		1010113
	b	If the carrier, service, or other organization incurre						
	O	retention of the contract or policy, other than repor	ted in Part I, line 2 abov	e, report amo	unt	10b		
	Spe	cify nature of costs.						
D.	. w.t.	Dravision of Information						
	art I					.,		
		d the insurance company fail to provide any informa		lete Schedule	A?	Yes	No	
12	If th	he answer to line 11 is "Yes," specify the information	n 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

2016

This Form is Open to Public

		pursuant to E	RISA section 103(a)(2).				Inspection	
For calendar plan year 20	16 or fiscal plan	year beginning 01/01/2016		and en	ding 12/3	1/2016		
A Name of plan HEALTH & LIFE PLAN FO	OR EMPLOYEE	S OF MILLIMAN, INC.		B Three	e-digit number (PN	N) <b>•</b>	501	
C Plan sponsor's name a MILLIMAN, INC.	as shown on line	e 2a of Form 5500			yer Identific 0675641	ation Number (	EIN)	
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca AETNA HEALTH INC.	rrier							
41 \ FIN	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year	
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To	
23-2169745	95109	0847207HNO	35		01/01/2016	3	12/31/2016	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. Lis	st in line 3	the agents,	brokers, and ot	ther persons in	
<b>(a)</b> Total a	amount of comr	missions paid		<b>(b)</b> To	tal amount	of fees paid		
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all p	persons).				
	(a) Name a	nd address of the agent, broker,	or other person to whon	n commiss	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fees	s and other commission	s paid				
commissions pa		(c) Amount	(	(d) Purpose			(e) Organization code	
	(a) Name a	nd address of the agent, broker,	or other person to whon	n commiss	ions or fees	were paid		
	(5)							
(b) Amount of sales ar	nd base	Fees	s and other commission	s paid		_		
commissions pa		(c) Amount	(	(d) Purpose			(e) Organization code	
	A ( N) (1						(= =====)	

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		<b>(e)</b> Organization	
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:			<u> </u>	
	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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	ane	Δ

P	art II						
		If more than one contract covers the same group of employed the information may be combined for reporting purposes if semployees, the entire group of such individual contracts with	such contracts are exp	erience-rated as a un	it. Where con	tract	s cover individual
8	Bene	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision) <b>b</b> Dental	С	Vision	(	Πt	Life insurance
	e 🗀		<u> </u>	∃ Supplemental unem	nlovment <b>i</b>	า⊟ี	Prescription drug
	ř	Stop loss (large deductible)		PPO contract		브	Indemnity contract
	' <u> </u>		illact <b>K</b>	_ FFO contract		'⊔	muemmity contract
	m	Other (specify)					
_							
		erience-rated contracts:	0-(4)				
		Premiums: (1) Amount received					
	,	(2) Increase (decrease) in amount due but unpaid					
	,	(4) Earned ((1) + (2) - (3))			9a(4)		
	_ `	Benefit charges (1) Claims paid			., Ja( <del>+)</del>		
		(2) Increase (decrease) in claim reserves	21 (2)				
	,	(3) Incurred claims (add (1) and (2))			9b(3)		
		(4) Claims charged			9b(4)		
	,	Remainder of premium: (1) Retention charges (on an accrual bas					
		(A) Commissions	´				
		(B) Administrative service or other fees	2 (1)(2)				
		(C) Other specific acquisition costs	0-(4)(0)				
		(D) Other expenses	9c(1)(D)				
		(E) Taxes	9c(1)(E)				
		(F) Charges for risks or other contingencies					
		(G) Other retention charges	9c(1)(G)		_		
		(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 afte	r retirement	9d(1)		
		(2) Claim reserves			9d(2)		
		(3) Other reserves			9d(3)		
		Dividends or retroactive rate refunds due. (Do not include amour	nt entered in line 9c(2)	<b>)</b> .)	9e		
10		onexperience-rated contracts:					
		Total premiums or subscription charges paid to carrier			10a		899136
		If the carrier, service, or other organization incurred any specific of			10b		
		retention of the contract or policy, other than reported in Part I, line ecify nature of costs.	ie z above, report am	ount	100		
	Opos						
Pa	art I\	IV Provision of Information					
		d the insurance company fail to provide any information necessary	to complete Schedule	e A?	Yes	No	 )
						. •0	·
14	ii tn	he 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

2016

		pursuant to	ERISA section 103(a)(2)				Inspection	
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016					ding 12/3	1/2016		
A Name of plan HEALTH & LIFE PLAN FO	OR EMPLOYE	ES OF MILLIMAN, INC.			e-digit number (PN	N) •	501	
C Plan sponsor's name a MILLIMAN, INC.	is shown on lir	ne 2a of Form 5500			oyer Identific 0675641	ation Number (	EIN)	
		rning Insurance Contract  A. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca CONNECTICARE, INC.	rrier							
	(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	
06-1537522	95675	0695	7	•	01/01/2016	6	12/31/2016	
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								
3 Persons receiving com		fees. (Complete as many entrie	· · · · · · · · · · · · · · · · · · ·					
	(a) Name	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		ees and other commission	ns paid				
commissions pa	id	(c) Amount		(d) Purpose	е		(e) Organization code	
	(a) Name	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	Fe	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code	

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		<b>(e)</b> Organization	
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	art	II Investment and Annuity Contract Information				
Where individual contracts are provided, the entire group of such individual contracts with this report.		ets with each carrier may	be treated	as a unit for purposes of		
4	Curr	ent value of plan's interest under this contract in the general account at year		4		
_		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:			<u> </u>	
	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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	ane	Δ

P	art II							
		If more than one contract covers the same of the information may be combined for reportion employees, the entire group of such individual.	ng purposes if such con	tracts are expe	erience-rated as a uni	t. Where con	tract	s cover individual
8	Benef	fit and contract type (check all applicable boxes)						
	a X	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		J [	Life insurance
	е □	Temporary disability (accident and sickness)	f Long-term disabil	itv <b>a</b>	Supplemental unem	plovment	า∏ี	Prescription drug
	ιH	Stop loss (large deductible)	j HMO contract		PPO contract	, ,	브	Indemnity contract
	m□	Other (specify)	, I invice definition		110 contract		•⊔	macrimity contract
	m _	Other (specify)						
9	Fyner	ience-rated contracts:						
•	•	remiums: (1) Amount received		9a(1)				
		Increase (decrease) in amount due but unpaid					Ì	
	,	3) Increase (decrease) in unearned premium rese						
	,	4) Earned ((1) + (2) - (3))				9a(4)		
	_ `	Benefit charges (1) Claims paid				, , ,		
	(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 F	Remainder of premium: (1) Retention charges (or	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)			ļ	
		(F) Charges for risks or other contingencies		9c(1)(F) 9c(1)(G)			-	
		(G) Other retention charges(H) Total retention				9c(1)(H)		
	,	` '	_	_				
		(2) Dividends or retroactive rate refunds. (These	<b>—</b>			9c(2)		
		Status of policyholder reserves at end of year: (1)	•			9d(1)		
	,	(2) Claim reserves(3) Other reserves				9d(2) 9d(3)		
	,	Dividends or retroactive rate refunds due. (Do no				9e		
10		experience-rated contracts:	t morade amount entere	a III IIII 0 30(2).	.,,			
. •		Total premiums or subscription charges paid to ca	arrier			10a		165413
		If the carrier, service, or other organization incurre						
		retention of the contract or policy, other than repo	, ,		•	10b		
		ify nature of costs.				<u>-</u>		
P	art I\	/ Provision of Information						
		the insurance company fail to provide any information	ation necessary to comp	lete Schedulo	Δ? Π	Yes	No	0
				iole Johendle	r:	100	140	<u> </u>
12	if the	e answer to line 11 is "Yes," specify the information	on 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

2016

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection					
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/20						1/2016	-			
A Name of plan HEALTH & LIFE PLAN FO	OR EMPLOYEE	ES OF MILLIMAN, INC.			e-digit number (PN	N) <b>•</b>	501			
C Plan sponsor's name a MILLIMAN, INC.	as shown on line	e 2a of Form 5500			oyer Identific 0675641	ation Number (	EIN)			
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.									
1 Coverage Information:										
(a) Name of insurance ca		F THE NORTHWEST								
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	contract year			
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To			
93-0798039	95540	11280	8		01/01/2016	6	12/31/2016			
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. Li	st in line 3	the agents,	brokers, and of	her persons in			
<b>(a)</b> Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount	of fees paid				
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,	or other person to whor	n commiss	ions or fees	were paid				
(b) Amount of sales ar	nd base	Fee	s and other commissior	ns paid						
commissions pa		(c) Amount		(d) Purpose			(e) Organization code			
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid				
		<b>y</b> , , ,	·			·				
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid						
commissions pa		(c) Amount	(d) Purpose				(e) Organization code			
	A . N .:		500							

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		<b>(e)</b> Organization	
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	art	II Investment and Annuity Contract Information				
Where individual contracts are provided, the entire group of such individual contracts with this report.		ets with each carrier may	be treated	as a unit for purposes of		
4	Curr	ent value of plan's interest under this contract in the general account at year		4		
_		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:			<u> </u>	
	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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	ane	Δ

Pa	art II						
		If more than one contract covers the same group of employee the information may be combined for reporting purposes if su employees, the entire group of such individual contracts with	ich contracts are expe	erience-rated as a uni	t. Where con	tracts	s cover individual
8	Bene	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision) <b>b</b> Dental	С	Vision	C	l k	Life insurance
	е 🗆	Temporary disability (accident and sickness) <b>f</b> Long-term	disability a	Supplemental unem	plovment <b>ľ</b>	า∏ี	Prescription drug
	i Η	Stop loss (large deductible) j HMO contr		PPO contract	,	브	Indemnity contract
	m	Other (specify)	<b></b>	1 1 0 continuot		- Ш	madrimity odmiradi
	m _	Other (specify) •					
9	Evnor	erience-rated contracts:					
_		Premiums: (1) Amount received	9a(1)				
		(2) Increase (decrease) in amount due but unpaid					
	•	(3) Increase (decrease) in unearned premium reserve					
	•	(4) Earned ((1) + (2) - (3))			. 9a(4)		
	_ `	Benefit charges (1) Claims paid					
	(	(2) Increase (decrease) in claim reserves	9b(2)				
	(	(3) Incurred claims (add (1) and (2))			9b(3)		
	(	(4) Claims charged			9b(4)		
	C	Remainder of premium: (1) Retention charges (on an accrual basis	s)				
		(A) Commissions					
		(B) Administrative service or other fees				ļ	
		(C) Other specific acquisition costs					
		(D) Other expenses	0-(4)(5)				
		(E) Taxes					
		(F) Charges for risks or other contingencies	0 (4)(0)				
		(G) Other retention charges(H) Total retention			9c(1)(H)		
		· '	. —				
		(2) Dividends or retroactive rate refunds. (These amounts were	· —		9c(2)		
		Status of policyholder reserves at end of year: (1) Amount held to p (2) Claim reserves			9d(1)		
		(3) Other reserves			9d(2) 9d(3)		
		Dividends or retroactive rate refunds due. (Do not include amount			9e		
10		enexperience-rated contracts:	- CINCIPO III IIIIO 00(2)	,,			
		Total premiums or subscription charges paid to carrier			10a		85926
		If the carrier, service, or other organization incurred any specific co					
		retention of the contract or policy, other than reported in Part I, line		•	10b		
	Spec	cify nature of costs.					
Pa	art I\	IV Provision of Information					
11	Did	d the insurance company fail to provide any information necessary to	o complete Schedule	A?	Yes	No	)
12	If th	he answer to line 11 is "Yes," specify the information not provided.	<u> </u>				

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

2016

			pursuant to	ERISA section 103(a)(2	).			Inspection
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016						nding 12/3	1/2016	
A Name of plants & LIF		OR EMPLOYE	ES OF MILLIMAN, INC.			e-digit number (PI	N) •	501
C Plan spons		s shown on lii	ne 2a of Form 5500		-	oyer Identific 0675641	ation Number (	EIN)
Part I			rning Insurance Contra  A. Individual contracts grouped					
1 Coverage Ir	nformation:							
(a) Name of ir			INC.					
		(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year
(b) E	IN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
94-1340523		48211		22	2	01/01/2016	6	12/31/2016
		mission inform amount paid.	nation. 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								
3 Persons red	ceiving com		fees. (Complete as many entrie					
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	lions or rees	were paid	
(b) Amoun	t of sales ar	nd base	<u> </u>	ees and other commission	ns paid			
comr	missions pai	d	(c) Amount		(d) Purpos	e		(e) Organization code
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
			<u> </u>				·	
(b) Amoun	t of sales ar	nd base	F	ees and other commissio	ns paid			
	missions pai		(c) Amount		(d) Purpos	e		(e) Organization code

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		<b>(e)</b> Organization	
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!		
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
		(3) other (specify)				
		(3) Totrier (specify)				
_	t	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma		• •		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
		_				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>&gt;</b>				
		(E) Total deductions			70/F\	
	£	(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	ane	Δ

Pa	art	Ш	Welfare Benefit Contract Informa	ation					
	4		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ontracts co	rganizations(s), ver individual
8	Ren	efit aı	nd contract type (check all applicable boxes)						
	г	_		<b>b</b> □ Dentel	٦	l Vicion		ما: ا	insurance
	a [	=	alth (other than dental or vision)	<b>b</b> Dental	<u> </u>	Vision		느	
	e [	Те	mporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	ployment	<b>h</b> Pre	scription drug
	i	Sto	op loss (large deductible)	j HMO contract	k	PPO contract		l Inde	emnity contract
	m	Ot	her (specify)						
<b>9</b> E	Ехре	erienc	e-rated contracts:						
	a I	Prem	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	l	9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)		
		(4) C	laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis)					
		(	(A) Commissions		9c(1)(A)				
		(	B) Administrative service or other fees		9c(1)(B)				
		(	(C) Other specific acquisition costs		9c(1)(C)			_	
		(	D) Other expenses		9c(1)(D)				
		(	(E) Taxes		9c(1)(E)			_	
		(	(F) Charges for risks or other contingencies .		9c(1)(F)				
		(	G) Other retention charges		9c(1)(G)		_		
		(	(H) Total retention				9c(1)(H	)	
		(2) [	Dividends or retroactive rate refunds. (These	amounts were paid ir	cash, or	credited.)	9c(2)		
	d	Stat	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) (	Claim reserves				9d(2)		
		(3) (	Other reserves				9d(3)		
	е	Divid	dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line <b>9c(2)</b>	.)	9e		
10	No	nexp	erience-rated contracts:						
	а	Tota	l premiums or subscription charges paid to c	arrier			10a		334127
	b	If the	e carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	h the acquisition or			
	_		ntion of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	ount	10b		
	Spe	cify n	ature of costs.						
Pa	art I	IV	Provision of Information						
11	Dic	the	insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	No	
12	If t	he an	swer to line 11 is "Yes," specify the informati	on 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

2016

pursuant to ERISA section 103(a)(2).					Inspection			
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016				and en	ding 12/3	1/2016		
A Name of plan HEALTH & LIFE PLAN FO	OR EMPLOYE	ES OF MILLIMAN, INC.			e-digit number (PN	N) •	501	
C Plan sponsor's name as shown on line 2a of Form 5500 MILLIMAN, INC.  D Employer Identification No. 91-0675641					ation Number (	EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca GROUP HEALTH COOPER								
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year	
<b>(b)</b> EIN	code	identification number		ons covered at end of licy or contract year		From	<b>(g)</b> To	
91-0511770	95672	0091500	68		01/01/2016	6	12/31/2016	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
0								
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	Fe	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	9		(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	Fe	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
( <b>a</b> ) Nai	ne and address of the agent, bio	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nar	me and address of the agent, bro	ker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nar	me and address of the agent, bro	ker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	ker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

_		•
חבע	Δ	- 5
ay		•

F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!		
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
		(3) other (specify)				
		(3) Totrier (specify)				
_	t	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma		• •		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on guarantee		
		(3) guaranteed investment (4) other	•			
		_				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>&gt;</b>				
		(E) Total deductions			70/F\	
	£	(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	ane	Δ

Pa	art II							
		If more than one contract covers the same group of emp the information may be combined for reporting purposes employees, the entire group of such individual contracts	if such contracts	are expe	erience-rated as a uni	t. Where cor	ntract	ts cover individual
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision) <b>b</b> Denta	ıl	С	Vision		d	Life insurance
	е 🗆		term disability	α	Supplemental unem	plovment	h∏	Prescription drug
	· H		contract		PPO contract	,	브	Indemnity contract
			Contract		110 contract		•⊔	macming contract
	m _	Other (specify)						
9	Evnor	prionee reted contracte:						
_		erience-rated contracts: Premiums: (1) Amount received	0.	a(1)				
		(2) Increase (decrease) in amount due but unpaid		a(2)			1	
	•	(3) Increase (decrease) in unearned premium reserve		a(3)				
	•	(4) Earned ((1) + (2) - (3))				9a(4)		
	_ `	Benefit charges (1) Claims paid		b(1)		1 00(.)		
		(2) Increase (decrease) in claim reserves		b(2)			1	
	,	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		
		(4) Claims charged				9b(4)		
	C	Remainder of premium: (1) Retention charges (on an accrual	basis)					
		(A) Commissions	9c(	1)(A)			]	
		(B) Administrative service or other fees		1)(B)			_	
		(C) Other specific acquisition costs		1)(C)			_	
		(D) Other expenses		1)(D)			4	
		(E) Taxes		1)(E)			-	
		(F) Charges for risks or other contingencies	- 1	1)(F)			4	
		(G) Other retention charges		1)(G)		0o/1\/U\		
		(H) Total retention	_	_		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These amounts we		_		9c(2)		
		Status of policyholder reserves at end of year: (1) Amount hel	·			9d(1)		
		(2) Char reserves				9d(2) 9d(3)		
		(3) Other reserves				90(3) 9e		
10		nexperience-rated contracts:	ount entered in in	10 3C(Z).	.)	36		
		Total premiums or subscription charges paid to carrier				10a		702424
	_	If the carrier, service, or other organization incurred any speci						
		retention of the contract or policy, other than reported in Part I			•	10b		
		cify nature of costs.						
Pa	art I\	V Provision of Information						
11	Did	d the insurance company fail to provide any information necess	ary to complete S	chedule	A?	Yes	N	0
12	If th	he answer to line 11 is "Yes," specify the information not provid	led. •				_	