Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2014

This Form is Open to Public Inspection

Part I		entification Information						
For caler	ndar plan year 2014 or fisca	al plan year beginning 10/01/2014		and ending 09/30/2	2015			
A This	eturn/report is for:	a multiemployer plan;	participating	a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or				
		X a single-employer plan; □	a DFE (speci	· · · —				
B This r	eturn/report is:	the first return/report;	the final retu	•				
		an amended return/report;	a short plan	year return/report (less than	n 12 month	s).		
C If the	plan is a collectively-barga	ined plan, check here				• [
D Chec	k box if filing under:	Form 5558;	automatic ex	tension;	the DF	FVC program;		
		special extension (enter description	<u> </u>		_			
Part	I Basic Plan Info	rmation—enter all requested informa	tion					
	ne of plan DNLY, INC				1b	Three-digit plan number (PN) ▶	503	
					1c	Effective date of pl 06/01/2005	an	
	sponsor's name and addre	ess; include room or suite number (emp	loyer, if for a single	-employer plan)	2b	Employer Identifica Number (EIN) 91-1212107	ation	
500 STR	ANDER BLVD	500 STRA	NDER BLVD		2c	Plan Sponsor's telenumber		
SEATTLE, WA 98188 SEATTLE, WA			WA 98188	2d Business code (see instructions) 443142			е	
Caution	A penalty for the late or	incomplete filing of this return/repor	t will be assessed	unless reasonable cause	is establis	shed.		
		r penalties set forth in the instructions, I Il as the electronic version of this return						
SIGN	Filed with authorized/valid	electronic signature.	04/11/2018	JERRY PROSIO				
HERE	Signature of plan admin		Date		nter name of individual signing as plan administrator			
SIGN	Olymature of plan autility	iisti atoi	Date	Effet frame of individual	Signing as	pian auministrator		
HERE	Signature of employer/p	olan sponsor	Date	Enter name of individual	signing as	employer or plan sp	onsor	
SIGN HERE								
Signature of DFE Date Enter name of individual signing as DFE								
(antion						telephone number		
JERRY F	PROSIO				(optional)	206-444-1655		
	NDER BLVD E, WA 98188							

Form 5500 (2014) Page **2**

3a	Plan administrator's name and address XSame as Plan Sponsor	3	3b Administrator's EIN		
			3	Administrator' number	s telephone
4	If the name and/or EIN of the plan sponsor has changed since the last return/report EIN and the plan number from the last return/report:	filed for this plan, enter th	e name, 4	b EIN	
а	Sponsor's name		4	C PN	
5	Total number of participants at the beginning of the plan year			5	101
6	Number of participants as of the end of the plan year unless otherwise stated (welfa 6a(2), 6b, 6c, and 6d).	re plans complete only lir	nes 6a(1) ,		
a(1) Total number of active participants at the beginning of the plan year		<u>6</u>	Sa(1)	101
a(2	Total number of active participants at the end of the plan year		<u>6</u>	Sa(2)	94
b	Retired or separated participants receiving benefits			6b	
С	Other retired or separated participants entitled to future benefits			6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c.			6d	94
е	Deceased participants whose beneficiaries are receiving or are entitled to receive b	enefits		6e	
f	Total. Add lines 6d and 6e .			6f	94
g	Number of participants with account balances as of the end of the plan year (only do complete this item)			6g	
h	Number of participants that terminated employment during the plan year with accrueless than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only multien	ployer plans complete th	is item)	7	
b	If the plan provides pension benefits, enter the applicable pension feature codes from the plan provides welfare benefits, enter the applicable welfare feature codes from 4A 4B 4D 4E 4F 4H 4R	n the List of Plan Characte	eristics Codes i	n the instructions	
9a		Plan benefit arrangement 1) X Insurance	(check all that a	apply)	
			on 412(e)(3) ins	surance contracts	
	H	3) Trust	. , , ,		
			sets of the spor		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached	l, and, where indicated, en	nter the number	r attached. (See	instructions)
а	Pension Schedules b	General Schedules			
	(1) R (Retirement Plan Information)	(1) H (Fin	nancial Informa	tion)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	nancial Informat	tion – Small Plan)	
	Purchase Plan Actuarial Information) - signed by the plan	` ′ 📙 ` `	surance Informa	•	
	actuary	· ·	ervice Provider		
	·, □ · • · ,			Plan Information)
	Information) - signed by the plan actuary	(6) G (Fi	nancial Transac	ction Schedules)	

Form 5500 (2014) Page **3**

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)					
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)						
If "Yes" is checke	If "Yes" is checked, complete lines 11b and 11c.					
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)						
11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)						
Receipt Confirmation Code						

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2014

This Form is Open to Public Inspection

For calendar plan year 20	14 or fiscal plan	year beginning 10/01/2014		and end	ding 09/30/2015	
A Name of plan VIDEO ONLY, INC				B Three-digit plan number (PN) 503		
C Plan sponsor's name a VIDEO ONLY, INC.	s shown on line	2a of Form 5500		D Employ 91-121	yer Identification Number (2107	EIN)
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
REGENCE BLUESHIELD						
/b) [IN	(c) NAIC	(d) Contract or	(e) Approximate num		Policy or co	ntract year
(b) EIN	code	identification number	persons covered at e policy or contract y		(f) From	(g) To
91-0282080	53902	10017657	94	1	10/01/2014	09/30/2015
2 Insurance fee and com- descending order of the		tion. Enter the total fees and total	commissions paid. List	t in line 3 t	the agents, brokers, and ot	her persons in
(a) Total a	amount of comn	nissions paid		(b) To	tal amount of fees paid	
		22192				
3 Persons receiving com	missions and fe	es. (Complete as many entries a	s needed to report all pe	ersons).		
	(a) Name ar	nd address of the agent, broker, o	or other person to whom	commissi	ions or fees were paid	
NORTHWEST BENEFIT	SOLUTIONS	611 4T KIRKL	H AVE STE 120 AND, WA 98033			
(b) Amount of sales ar	nd hase	Fees	and other commissions	s paid		
commissions pa		(c) Amount	(d	d) Purpose	9	(e) Organization code
	22192	7361 BO	NUS			3
	(a) Name ar	nd address of the agent, broker, o	or other person to whom	commissi	ions or fees were paid	
(b) Amount of sales and base Fees and other commissions paid						
commissions pa		(c) Amount	(d	d) Purpose	9	(e) Organization code
For Panerwork Reduction	n Act Notice a	nd OMB Control Numbers see	the instructions for Fo	rm 5500		

Schedule A (Form 5500) 2014 Page 2 - 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

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

Page 4		
me employer(s) or members of the experience-rated as a unit. Who ated as a unit for purposes of this	ere contra	
c ☐ Vision g ☐ Supplemental unemp k ☐ PPO contract	oloyment	d ☐ Life insurance h ☐ Prescription drug l ☐ Indemnity contract
9a(1)	48223	0
9a(2)	40223	0
9a(3)		
	9a(4)	482230
9b(1)		
9b(2)	1	
	9b(3)	
	9b(4)	

Schedule A (Form 5500) 2014

P	art I	If more than one contract covers the same g		ame emplov	er(s) or members of th	e same em	plovee organizations(s).	the
		information may be combined for reporting p	urposes if such contracts a	re experienc	ce-rated as a unit. Who	ere contrac		
8	Ben	efit and contract type (check all applicable boxes)			The for purposes of this	торот.		
•	a [¬	b Dental	сГ	Vision		d Life insurance	
	L	Temporary disability (accident and sickness)	. H	<u> </u>	<u>]</u>	la mant	=	
	e					noyment	<u></u>	
	'	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	t
	m	Other (specify)						
9		ovience voted contractor						
J		erience-rated contracts: Premiums: (1) Amount received	Г	9a(1)		482230		
	u	(2) Increase (decrease) in amount due but unpair		9a(1)		402230		
		(3) Increase (decrease) in unearned premium res	_	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		482230
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves	<u> </u>					
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (c	on an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs	<u> </u>	9c(1)(C)				
		(D) Other expenses	<u> </u>	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	<u> </u>			9c(2)		
	d	Status of policyholder reserves at end of year: (1	•			9d(1)		
		(2) Claim reserves				9d(2)		
	_	(3) Other reserves				9d(3)		
1() Nic	Dividends or retroactive rate refunds due. (Do nonexperience-rated contracts:	ot include amount entered	in line 90(2)	.)	9e		
.,		Total premiums or subscription charges paid to	parrier			10a		
	b	If the carrier, service, or other organization incur				iva		
	~	retention of the contract or policy, other than rep			•	10b		
	S	pecify nature of costs		•				

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

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

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2014

This Form is Open to Public

			ERISA section 103(a)(2).	c iiiioiiiiati	1011		Inspection
For calendar plan year 20	14 or fiscal plar	n year beginning 10/01/2014		and en	ding 09	/30/2015	
A Name of plan VIDEO ONLY, INC				B Three plan	e-digit number (PI	N) •	503
C Plan sponsor's name a VIDEO ONLY, INC.				91-121	2107	cation Number	
		ing Insurance Contract Individual contracts grouped as					
1 Coverage Information:	le Scriedule A.	maindal contracts grouped as	s a unit in r arts ir and in co	an be repo	orted on a s	ingle ochedule	; Λ.
(a) Name of insurance ca	rrier						
THE LINCOLN NATIONA	AL LIFE INSUR	ANCE COMPANY					
(I.) FIN	(c) NAIC	(d) Contract or	(e) Approximate nun			Policy or c	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
35-0472300	65676	00001D024876	96	5	10/01/20)14	09/30/2015
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. Lis	t in line 3 t	the agents,	brokers, and o	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		7236					
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all p	ersons).			
		nd address of the agent, broke	·	commissi	ions or fees	were paid	
NORTHWEST BENEFIT	SOLUTIONS, I	INC 611 KIRI	4TH AVE STE120 KLAND, WA 98033				
							_
(b) Amount of sales ar	nd base	Fe	es and other commissions	s paid			
commissions pa		(c) Amount	(0	d) Purpose	9		(e) Organization code
	7236						3
	(a) Nama a	and address of the agent broke	r or other person to whom	oommissi	ione or food	wore poid	
	(a) Name a	and address of the agent, broke	, or other person to whom	COMMISSI	ions or rees	were paid	
(b) Amount of sales ar	nd base	Fe	es and other commissions	s paid			
commissions pa		(c) Amount	(0	d) Purpose	Э		(e) Organization code

Schedule A (Form 5500) 2014 Page 2 - 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts	s with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
-		tracts With Allocated Funds:			•	ı
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	n guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	7.41			
		(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)			
		•				
		(F) Total daductions			7e(5)	
	f	(5) Total deductions			76(3) 7f	

Schedule A (Form 5500) 2014		Paç	ge 4	
Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the sa urposes if such contracts ar	re experienc	e-rated as a unit. Where contra	
efit and contract type (check all applicable boxes)				
Health (other than dental or vision)	b X Dental	С	Vision	d Life insurance
Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k ∏	PPO contract	I Indemnity contract
Other (specify)		_		
_				
erience-rated contracts:	_			
Premiums: (1) Amount received		9a(1)	7235	6
(2) Increase (decrease) in amount due but unpai	d	9a(2)		
(3) Increase (decrease) in unearned premium re-		9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)	7235
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)	
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 enecific acquisition costs		9c(1)(C)		

9c(1)(H)

9c(2)

9d(1)

9d(2)

9d(3)

9e

10a

10b

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

10 Nonexperience-rated contracts:

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

m ☐ Other (specify) ▶

Experience-rated contracts:

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

Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions (B) Administrative service or other fees..... (C) Other specific acquisition costs (D) Other expenses.....

(E) Taxes.....

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

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

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

(2) Claim reserves

(3) Other reserves.....

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

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

Part III

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

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

9c(1)(F)

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

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2014

This Form is Open to Public

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			ation	Inspection			
For calendar plan year 20	14 or fiscal pla	n year beginning 10/01/2014	and e	ending 09/30/2015	5		
A Name of plan VIDEO ONLY, INC				ee-digit in number (PN)	503		
C Plan sponsor's name a VIDEO ONLY, INC.	umber (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:							
1 Coverage Information:							
(a) Name of insurance ca	rrier						
VISION SERVICE PLAN							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		cy or contract year		
(8) 2	code	identification number	policy or contract year	(f) From	(g) To		
23-7089668	53031	30035922	91	10/01/2014	09/30/2015		
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. List in line	3 the agents, brokers	, and other persons in		
-	amount of com	missions paid	(b)	Total amount of fees p	paid		
		658					
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all persons).				
NODEL IMPORT DENIETIE	· · ·	and address of the agent, broker,		ssions or fees were pa	aid		
NORTHWEST BENEFIT	SOLUTIONS,		TH AVE STE 120 LAND, WA 98033				
(b) Amount of sales a commissions pa		(c) Amount	s and other commissions paid (d) Purpo	se	(e) Organization code		
	658		(1)		3		
	()))			. ,	.,		
	(a) Name a	and address of the agent, broker,	or other person to whom commis	ssions or tees were pa	AIG .		
(b) Amount of sales a	nd base _	Fee	s and other commissions paid				
commissions pa	id	(c) Amount	(d) Purpo	se	(e) Organization code		

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(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid					
	-						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(a) Na	line and address of the agent, broke	er, or other person to whom commissions or rees were paid					
		Fees and other commissions paid	T				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
	(0)	(2)					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid					
(4)	and and address of the agent, protect	n, et estici person to mism commissions et rece maio paid					
(h) Amount of a deal and have		Fees and other commissions paid	(-) () (
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid					
	T		1				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts	s with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
-		tracts With Allocated Funds:			•	ı
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	n guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	7.41			
		(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)			
		•				
		(F) Total daductions			7e(5)	
	f	(5) Total deductions			76(3) 7f	

Page 4	
nployer(s) or members of the same en erience-rated as a unit. Where contracts as a unit for purposes of this report.	. , .
c X Vision	d Life ins
g Supplemental unemployment	_ =

		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts w	urposes if such contracts a	are experienc	e-rated as a unit. Whe	ere contract		
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	c×	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unemp	loyment	h Prescription dru	ıg
	i [Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contr	act
	m	Other (specify)						
9	=yne	erience-rated contracts:						
-	•	Premiums: (1) Amount received	[9a(1)		8154	₫	
		(2) Increase (decrease) in amount due but unpaid				0104	┥	
		(3) Increase (decrease) in unearned premium res					-	
		(4) Earned ((1) + (2) - (3))	<u>-</u>			9a(4)		8154
	_	Benefit charges (1) Claims paid	T T	1		(/		
		(2) Increase (decrease) in claim reserves					1	
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder 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	L	9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention		_	•	9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	·			9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide I	penefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
40		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2) .)	9e		
10		nexperience-rated contracts:			Γ			
		Total premiums or subscription charges paid to c				10a		
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b		
	Sp	pecify nature of costs						

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

Schedule A (Form 5500) 2014

Welfare Benefit Contract Information

Part III

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