## Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor

## Annual Return/Report of Employee Benefit Plan

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

▶ Complete all entries in accordance with

OMB Nos. 1210-0110 1210-0089

2017

-	Administration	the instructions to the Form 5500.							
Pensio	on Benefit Guaranty Corporation				This	Form is Open to Pu Inspection	ıblic		
Part I	Annual Report Ide	entification Information							
For cale	ndar plan year 2017 or fisca	al plan year beginning 01/01/2017		and ending 12/31/20	)17				
A This	return/report is for:	a multiemployer plan		loyer plan (Filers checking the manning the manning the manning that the manning the manning that the manning the manning the manning the manning the manning that the manning			ns.)		
		x a single-employer plan	a DFE (specify	)					
<b>B</b> This	return/report is:	the first return/report	the final return/	·					
		an amended return/report	a short plan ye	ar return/report (less than 12	2 months)	1			
C If the	plan is a collectively-bargai	ined plan, check here				•			
<b>D</b> Chec	k box if filing under:	Form 5558	automatic exten	sion	the	e DFVC program			
		special extension (enter description)	<u> </u>						
Part II	Basic Plan Inform	nation—enter all requested informatio	n						
	ne of plan	D MEDICAL, DENTAL, LIFE/AD&D & I		NCE PLAN	1b	Three-digit plan number (PN) ▶	501		
					1c	Effective date of pla 01/01/1984	an		
Mail	ing address (include room,	r, if for a single-employer plan) apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code	(if foreign, see instru	uctions)	2b Employer Identification Number (EIN) 91-0869056		tion		
SEATTLI	E INDIAN HEALTH BOARD	)			<b>2c</b> Plan Sponsor's telephone number 206-324-9360				
PO BOX SEATTLI	3364 E, WA 98114-3364	611 12TH AVE S. SEATTLE, WA 98144			2d	Business code (see instructions) 621399	<del>,</del>		
Caution	: A penalty for the late or	incomplete filing of this return/repor	t will be assessed ເ	unless reasonable cause is	s establis	shed.			
		r penalties set forth in the instructions, I Il as the electronic version of this return							
SIGN HERE	Filed with authorized/valid	electronic signature.	05/16/2018	PAM GRINDLEY					
	Signature of plan admin	istrator	Date	Enter name of individual si	igning as	plan administrator			
SIGN HERE									
HERE		<del>-</del>							

Date

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Signature of employer/plan sponsor

Signature of DFE

SIGN **HERE** 

> Form 5500 (2017) v. 170203

Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

	F 5500 (0047)	D	2			
3a	Form 5500 (2017)  Plan administrator's name and address X Same as Plan Sponsor	Pa	age <b>2</b>		<b>3b</b> Admin	nistrator's EIN
					3c Admin	istrator's telephone er
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the enter the plan sponsor's name, EIN, the plan name and the plan number from the				4b EIN	
a C	Sponsor's name Plan Name	idot rotu	Титор	oru.	4d PN	
5	Total number of participants at the beginning of the plan year				5	176
6	Number of participants as of the end of the plan year unless otherwise stated (well <b>6a(2), 6b, 6c,</b> and <b>6d</b> ).	fare plar	s com	nplete only lines 6a(1),		
a(	1) Total number of active participants at the beginning of the plan year				<mark>6a(1)</mark>	176
a(	2) Total number of active participants at the end of the plan year				6a(2)	161
b	Retired or separated participants receiving benefits				6b	2
	Other retired or separated participants entitled to future benefits				6c	0
	Subtotal. Add lines 6a(2), 6b, and 6c.				6d	163
e	Deceased participants whose beneficiaries are receiving or are entitled to receive				6e 6f	
f	Total. Add lines <b>6d</b> and <b>6e</b>				01	
g	complete this item)				6g	
h	Number of participants who terminated employment during the plan year with accr less than 100% vested				6h	
7	Enter the total number of employers obligated to contribute to the plan (only multie	employer	plans	complete this item)	7	
	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 4H 4L 4Q					
9a	Plan funding arrangement (check all that apply)  (1)	Plan be (1) (2) (3) (4)	nefit a	arrangement (check all the Insurance Code section 412(e)(3 Trust General assets of the s	) insurance c	ontracts
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached	ed, and,	where	indicated, enter the num	nber attached	I. (See instructions)
а	Pension Schedules b		al Sch	nedules		
	(1) R (Retirement Plan Information)	(1)	П	H (Financial Info	rmation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)		I (Financial Infor	mation – Sm	all Plan)
	Purchase Plan Actuarial Information) - signed by the plan	(3)	X	6 A (Insurance Info	ormation)	

(4) (5)

(6)

C (Service Provider Information)

**D** (DFE/Participating Plan Information)

**G** (Financial Transaction Schedules)

actuary

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

(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.)					
<b>11b</b> Is the	plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)				
Recei	the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the pt 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 pt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)				
Rece	ipt Confirmation Code				

Form 5500 (2017)

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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

2017

numbers of EDICA continues $102(a)(2)$					m is Open to Public Inspection		
For calendar plan year 20	17 or fiscal pla	an year beginning 01/01/2017		and en	iding 12/31	/2017	
A Name of plan SEATTLE INDIAN HEAL' INSURANCE PLAN	TH BOARD M	EDICAL, DENTAL, LIFE/AD&D	& DISABILITY		e-digit number (PN	) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 SEATTLE INDIAN HEALTH BOARD  D Employer Identification Number (E 91-0869056)						(EIN)	
		erning Insurance Contract  A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		OF WASHINGTON					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			•	ontract year
(0) =	code	identification number	policy or contract		(f)	From	<b>(g)</b> To
91-0511770	95672	1654200	79	)	01/01/2017		12/31/2017
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, b	rokers, and c	other persons in
<b>(a)</b> Total :	amount of con	nmissions paid		<b>(b)</b> To	otal amount o	f fees paid	
		32389					0
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees v	vere paid	
DIGITAL INSURANCE INC		STE	GALLERIA PKWY 1950 NTA, GA 30339				
(b) Amount of sales a	nd base	Fe	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
32389						3	
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees v	vere paid	
	(2) . (2)	and dadress of the agent, prend	., o.			. о. о раза	
(b) Amount of sales a	nd hase	Fe	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	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)			
		•	(-)			
		,				
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

P	art l	III Welfare Benefit Contract Informa	tion					
		If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	ng purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ontracts cover individual	
8	Bene	nefit and contract type (check all applicable boxes)			<u> </u>		·	_
	a D	X Health (other than dental or vision)	<b>b</b> Dental	сГ	Vision		<b>d</b> Life insurance	
	느		봄	<u> </u>	<u></u>		H	
	e	,	f Long-term disabilit	· - =	Supplemental unem	pioyment	h ☐ Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Expe	erience-rated contracts:	·					
	a F	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese	erve	9a(3)				
	_	(4) Earned ((1) + (2) - (3))				. 9a(4)		C
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves	· ·					
		(3) Incurred claims (add (1) and (2))				. 9b(3)		C
		(4) Claims charged				. 9b(4)		_
	С	Remainder of premium: (1) Retention charges (or	·	2 (4)(4)				
		(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 (G) Other retention charges		9c(1)(G)				
		(H) Total retention	•			9c(1)(H	1	
		(2) Dividends or retroactive rate refunds. (These					<i>)</i>	_
	٦		_	_				_
	d	Status of policyholder reserves at end of year: (1) (2) Claim reserves	•			9d(1)		_
		(3) Other reserves				9d(2) 9d(3)		_
	е	Dividends or retroactive rate refunds due. (Do no						_
10		pnexperience-rated contracts:	i include amount entered	1 111 1111e 3C(2)	.)	., 36		
		Total premiums or subscription charges paid to ca	arrier			. 10a	65029	95
		If the carrier, service, or other organization incurre				100	00020	_
	D	retention of the contract or policy, other than repo				10b		
	Spe	ecify nature of costs.		-,		1	<b>.</b>	_
Pa	art I	IV Provision of Information						
11	Dic	d the insurance company fail to provide any informa	ation necessary to compl	ete Schedule	A?	Yes	X No	
		the answer to line 11 is "Yes," specify the information						_

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

2017

		to ERISA section 103(a)(2).	This Fo	orm is Open to Public Inspection
For calendar plan year 2017 or fis	cal plan year beginning 01/01/2017	7 and e	nding 12/31/2017	
A Name of plan SEATTLE INDIAN HEALTH BOA INSURANCE PLAN	RD MEDICAL, DENTAL, LIFE/AD&I	O & DICABILITY	ee-digit n number (PN)	501
C Plan sponsor's name as shown SEATTLE INDIAN HEALTH BOA	loyer Identification Numbe -0869056			
		act Coverage, Fees, and Co d as a unit in Parts II and III can be re		
1 Coverage Information:				
	PLAN OF WASHINGTON OPTIONS	, INC.  (e) Approximate number of	Policy or	contract year
	NAIC (d) Contract or identification number	persons covered at end of policy or contract year	(f) From	(g) To
91-1467158 47055	8161700	109	01/01/2017	12/31/2017
2 Insurance fee and commission descending order of the amoun		total commissions paid. List in line 3	3 the agents, brokers, and	other persons in
(a) Total amount	of commissions paid	(b) T	otal amount of fees paid	
	35999			0
3 Persons receiving commissions	s and fees. (Complete as many entr	ies as needed to report all persons).		
		ker, or other person to whom commis	sions or fees were paid	
DIGITAL INSURANCE INC	STE	GALLERIA PKWY E 1950 ANTA, GA 30339		
(b) Amount of sales and base		Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpo:	se	(e) Organization code
359	999			3
(a) N	Name and address of the agent, brok	ker, or other person to whom commis	sions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpo	se	(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	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)			
		•	(-)			
		,				
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the ng purposes if such contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	X Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v <b>a</b>	Supplemental	unemplovment	h Prescription drug
	i [	Stop loss (large deductible)	j ∏ HMO contract	, S k	=		I  Indemnity contract
	m	Other (specify)	,e coac.	1			
	"""	_ Other (specify) F					
9	Exp	erience-rated contracts:					
Ŭ		Premiums: (1) Amount received		9a(1)			_
	ŭ	(2) Increase (decrease) in amount due but unpaid	•	9a(2)			_
		(3) Increase (decrease) in unearned premium rese		9a(3)			
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)		1 7	
		(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	(
		(4) Claims charged					
	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)		T	
		(H) Total retention	_				(
		(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 I	benefits afte	er retirement	9d(1)	
		(2) Claim reserves					
		(3) Other reserves					
	е	Dividends or retroactive rate refunds due. (Do not	t include amount entered	l in line 9c(2	<b>2)</b> .)	9e	
1(	) No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			10a	733392
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than report					
	Specify nature of costs.						
F	art	IV Provision of Information					
11	Die	d the insurance company fail to provide any informa	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	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.

OMB No. 1210-0110

2017

nursuant to FDICA continu 402(a)(2)						m is Open to Public Inspection	
For calendar plan year 20°	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2	2017	
A Name of plan SEATTLE INDIAN HEALT INSURANCE PLAN	SEATTLE INDIAN HEALTH BOARD MEDICAL, DENTAL, LIFE/AD&D				e-digit n number (PN)	<b>•</b>	501
C Plan sponsor's name a SEATTLE INDIAN HEALT		ne 2a of Form 5500		-	oyer Identification	on Number	(EIN)
		rning Insurance Contract. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca							
/h) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		<b>(f)</b> Fr	rom	<b>(g)</b> To
91-0621480	47341	06223	204	ļ	01/01/2017		12/31/2017
2 Insurance fee and coming descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, bro	okers, and c	other persons in
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount of	fees paid	
12103 0							
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	sions or fees we	ere paid	
DIGITAL INSURANCE INC	C. ANDONIAN		WOLLOCHET DR NW HARBOR, WA 98335				
(b) Amount of sales ar	nd hase	Fe	es and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
	12103						3
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	sions or fees we	ere paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
Commissions paid (C) Amount							

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1			
(a) No.			omicciono ar foco ware noid			
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid			
4.1.		Fees and other commissions	paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code		
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid			
(-)		,				
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization		
commissions paid	(c) Amount	((	code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
	<u> </u>					
(b) Amount of sales and base		Fees and other commissions p		(e) Organization		
commissions paid	(c) Amount	(1	d) Purpose	code		
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid			
		Fees and other commissions p	naid	(e)		
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code		
commissions paid		,	<u>,                                      </u>	code		
(1)						
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid			
Fees and other commissions paid (e)						
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code		

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of				
4 Current value of plan's interest under this contract in the general account at year end										
		rent value of plan's interest under this contract in separate accounts at year e			5					
		tracts With Allocated Funds:			1 - 1					
·	a	State the basis of premium rates								
	b	Premiums paid to carrier			6b					
	С	Premiums due but unpaid at the end of the year			6c					
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d					
		Specify nature of costs								
	е	Type of contract: (1) individual policies (2) group deferred	d annuity							
		(3) dother (specify)								
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here						
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma								
-	а	Type of contract: (1) deposit administration (2) immedia								
	u			on gaarantoo						
		(3) guaranteed investment (4) other								
	b	Balance at the end of the previous year			. 7b	0				
	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)							
		•	(-)							
		,								
		(6)Total additions			. 7c(6)	0				
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0				
	е	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)							
		\(\frac{1}{2} \)	( - /							
		•								
		(5) Total deductions			. 7e(5)	0				

0

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F	art	Welfare Benefit Contract Inform	ation					
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual to the contract of the same than the contract covers the same that the contract covers the same that the covers the contract covers the same that the covers the covers the same that the covers the covers the same that the covers the covers the same that the covers the cove	ting purposes if such cont	racts are exp	perience-rated as a un	it. Where co	ontracts cover i	
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> X Dental	с	Vision		d Life insu	urance
	е	Temporary disability (accident and sickness)	f Long-term disabili	L	Supplemental unen	anloymont	h Prescrip	
	: [					ipioyment		_
	'	Stop loss (large deductible)	j  HMO contract	ĸ	PPO contract		I Indemni	ity contract
	m	Other (specify)						
_								
9		erience-rated contracts:		- (1)	1			
		Premiums: (1) Amount received		9a(1)		119668		
		(2) Increase (decrease) in amount due but unpai				0		
		(3) Increase (decrease) in unearned premium res				00(4)		119668
	b	(4) Earned ((1) + (2) - (3))				<b>9a(4)</b> 84363	1	119000
	D	(2) Increase (decrease) in claim reserves				4000		
		(3) Incurred claims (add (1) and (2))					<u> </u>	88363
		(4) Claims charged				9b(4)		88363
	С	Remainder of premium: (1) Retention charges (c				02(1)		
		(A) Commissions	,	9c(1)(A)		12103	3	
		(B) Administrative service or other fees				15420		
		(C) Other specific acquisition costs		0 (4)(0)		C		
		(D) Other expenses		0.74170		0		
		(E) Taxes		9c(1)(E)		0	)	
		(F) Charges for risks or other contingencies.				0	)	
		(G) Other retention charges		9c(1)(G)		0		
		(H) Total retention					)	27523
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	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)		6000
		(3) Other reserves				` '		(
		Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2	( <b>)</b> .)	9e		(
1(	) No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to o	carrier	•••••		<u>10a</u>		
	b	If the carrier, service, or other organization incur			•	10h		
	Sne	retention of the contract or policy, other than rep cify nature of costs.	orted in Part I, line 2 abov	e, report am	ount	10b		
	Орс	sily flatare or occio.						
P	art	V Provision of Information						
11		I the insurance company fail to provide any inform	nation necessary to comp	lete Schedul	e A?	Yes	X No	
		ne answer to line 11 is "Yes," specify the informat		22.30001				

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

2017

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 20	17 or fiscal plan	year beginning 01/01/2017		and en	ding 12/3	1/2017	
A Name of plan SEATTLE INDIAN HEAL INSURANCE PLAN	ΓΗ BOARD ME	DICAL, DENTAL, LIFE/AD&D & I	DISABILITY		e-digit number (PN	N) <b>•</b>	501
C Plan sponsor's name a SEATTLE INDIAN HEALT		e 2a of Form 5500		-	oyer Identific 0869056	ation Number (	EIN)
		ning Insurance Contract  Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca VISION SERVICE PLAN	rrier						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
23-7089668	53031	30073268	124	1	01/01/2017	7	12/31/2017
2 Insurance fee and com- descending order of the		ation. Enter the total fees and total	ıl 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							
	1064 0						
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
		nd address of the agent, broker,		m commiss	ions or fees	were paid	
DIGITAL INSURANCE, IN	0	STE 19:	LLERIA PKWY SE 50 FA, GA 30339-5946				
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	1064						3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
		<u> </u>				·	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1			
(a) No.			omicciono ar foco ware noid			
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid			
4.1.		Fees and other commissions	paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code		
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid			
(-)		,				
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization		
commissions paid	(c) Amount	((	code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
	<u> </u>					
(b) Amount of sales and base		Fees and other commissions p		(e) Organization		
commissions paid	(c) Amount	(1	d) Purpose	code		
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid			
		Fees and other commissions p	naid	(e)		
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code		
commissions paid		,	<u>,                                      </u>	code		
(1)						
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid			
Fees and other commissions paid (e)						
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code		

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of				
4 Current value of plan's interest under this contract in the general account at year end										
		rent value of plan's interest under this contract in separate accounts at year e			5					
		tracts With Allocated Funds:			1 - 1					
·	a	State the basis of premium rates								
	b	Premiums paid to carrier			6b					
	С	Premiums due but unpaid at the end of the year			6c					
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d					
		Specify nature of costs								
	е	Type of contract: (1) individual policies (2) group deferred	d annuity							
		(3) dother (specify)								
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here						
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma								
-	а	Type of contract: (1) deposit administration (2) immedia								
	u			on gaarantoo						
		(3) guaranteed investment (4) other								
	b	Balance at the end of the previous year			. 7b	0				
	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)							
		•	(-)							
		(6)Total additions			. 7c(6)	0				
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0				
	е	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)							
		\(\frac{1}{2} \)	( - /							
		•								
		(5) Total deductions			. 7e(5)	0				

0

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P	art l	III Welfare Benefit Contract Informa	tion				
		If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	ng purposes if such conti	acts are expe	erience-rated as a un	it. Where co	ontracts cover individual
8	Bene	efit and contract type (check all applicable boxes)			<u> </u>	-	i
	аΓ	Health (other than dental or vision)	<b>b</b> Dental	c×	Vision		<b>d</b> Life insurance
	느				<u></u>		
	e		f Long-term disabilit		Supplemental unem	ipioyment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Expe	erience-rated contracts:	,				
	a F	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)			
	_	(4) Earned ((1) + (2) - (3))				9a(4)	C
	b	Benefit charges (1) Claims paid		9b(1)			_
		(2) Increase (decrease) in claim reserves				T	
		(3) Incurred claims (add (1) and (2))				. 9b(3)	C
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (or	Ī	0 (4)(4)			_
		(A) Commissions	l	9c(1)(A)			_
		(B) Administrative service or other fees	ŀ	9c(1)(B) 9c(1)(C)			_
		(C) Other specific acquisition costs	ľ	9c(1)(C)			_
		(D) Other expenses					_
		(E) Taxes(F) Charges for risks or other contingencies		9c(1)(E)			_
		(G) Other retention charges		9c(1)(G)			_
		(H) Total retention	·			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These					
	d	Status of policyholder reserves at end of year: (1)		_			
	u	(2) Claim reserves	•			9d(1)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no					
10		onexperience-rated contracts:			.,	.,	
-		Total premiums or subscription charges paid to ca	arrier			. 10a	18866
	_	If the carrier, service, or other organization incurre					
	~	retention of the contract or policy, other than repo			•	. 10b	
	Spe	ecify nature of costs.					
_		nt Decision of the					
Pa	art I	IV Provision of Information			-		
		d the insurance company fail to provide any informa		ete Schedule	A?	Yes	X No
12	lf th	he 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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

		parsaant to E	1110A 30011011 103(a)(2).		Inspection		
For calendar plan year 20°	17 or fiscal plar	year beginning 01/01/2017	and	d ending 12/31/2017			
A Name of plan SEATTLE INDIAN HEALT INSURANCE PLAN	TH BOARD ME	DICAL, DENTAL, LIFE/AD&D &	DISABILITY	hree-digit blan number (PN)	501		
C Plan sponsor's name a	s shown on line	e 2a of Form 5500	<b>D</b> En	nployer Identification Numbe	er (EIN)		
SEATTLE INDIAN HEALT	H BOARD			91-0869056			
Part I Informat on a separa	ion Concer ate Schedule A	ning Insurance Contract . Individual contracts grouped as	Coverage, Fees, and C s a unit in Parts II and III can be	commissions Provide into e reported on a single Sched	formation for each contract dule A.		
1 Coverage Information:							
(a) Name of insurance car PRUDENTIAL INSURANC		DF AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate number of		contract year		
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To		
22-1211670	68241	02046	161	01/01/2017	12/31/2017		
2 Insurance fee and communication descending order of the		ation. Enter the total fees and tota	al commissions paid. List in lin	e 3 the agents, brokers, and	l other persons in		
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid						
		6346			54		
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all persons	s).			
		nd address of the agent, broker,		nissions or fees were paid			
DIGITAL INSURANCE INC	;		1950 ILLERIA PKWY TA, GA 30339				
<b>(b)</b> Amount of sales ar	nd hase	Fee	s and other commissions paid				
commissions pai		(c) Amount	(d) Pur	pose	(e) Organization code		
	6346				3		
	(a) Name a	nd address of the agent, broker,	or other person to whom comm	nissions or fees were paid			
AXA ASSISTANCE, USA	(4)		OUTH MICHIGAN AVENUE				
		SUITE CHICA	1100 GO, IL 60603-6115				
(b) Amount of sales ar	nd hase	Fee	s and other commissions paid				
commissions pai		(c) Amount	<b>(d)</b> Pur <sub>l</sub>	pose	(e) Organization code		
	0	54 TH	HIRD PARTY ADMINISTRATIO	DN FEES	5		

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	III Welfare Benefit Contract Informal 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 ting purposes if such contr	acts are exp	erience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> X Life insurance
	е	Temporary disability (accident and sickness)	f X Long-term disabilit	v a	Supplemental	unemployment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	·	PPO contract		I  Indemnity contract
	m	☐ Stop ioss (large deductible)  X Other (specify) ►AD&D, VOL LIFE, VOL DEP	<i>-</i> ⊔	<u> </u>			I Indemnity contract
	m	Other (specify) PAD&D, VOL LIFE, VOL DEP	LIFE SPOUSE/FAIVI, VO	L CHILD LIF	Έ		
a	Evn	erience-rated contracts:					
9		Premiums: (1) Amount received	]	9a(1)			
	а	(2) Increase (decrease) in amount due but unpaid		9a(1)			
		(3) Increase (decrease) in unearned premium res		9a(3)			_
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)		Ju(+)	
	~	(2) Increase (decrease) in claim reserves		9b(2)			_
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (c		•••••			
	·	(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	•		I	9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These					
	А		_				
	d	Status of policyholder reserves at end of year: (1 (2) Claim reserves	•			· · · · ·	
		( )				2 1(2)	
	е	(3) Other reserves  Dividends or retroactive rate refunds due. (Do n					
1(		onexperience-rated contracts:	of include amount entered	1 111 111116 30(2)	<i>J</i> .)	<del>Je</del>	
.,	a	Total premiums or subscription charges paid to c	carriar			10a	63463
	-	, , ,					0340
	b Sne	If the carrier, service, or other organization incuru- retention of the contract or policy, other than rep- ecify nature of costs.					
F	art	IV Provision of Information					_
1	l Di	d the insurance company fail to provide any inform	nation necessary to compl	ete Schedule	e A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the informat	ion 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

2017

This Form is Open to Public

		pursuant to EF	RISA section 103(a)(2).				Inspection
For calendar plan year 20	017 or fiscal plar	n year beginning 01/01/2017		and en	ding 12/3	31/2017	
A Name of plan SEATTLE INDIAN HEALTH BOARD MEDICAL, DENTAL, LIFE/AD&D & DIS INSURANCE PLAN			DISABILITY	B Three plan	e-digit number (PI	N) <b>•</b>	501
C Plan sponsor's name as shown on line 2a of Form 5500 SEATTLE INDIAN HEALTH BOARD  D Employer Identification Number (EIN) 91-0869056					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 of COLONIAL LIFE & ACCID		ICE COMPANY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate num persons covered at e			Policy or co	ontract year
(b) EIN	code	identification number	policy or contract y		(f)	From	<b>(g)</b> To
57-0144607	62049	E8936759	44		01/01/201	7	12/31/2017
2 Insurance fee and con descending order of th		ation. Enter the total fees and total	commissions paid. List	t in line 3 t	the agents,	brokers, and of	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
9895 4368							
3 Persons receiving con	nmissions and fe	ees. (Complete as many entries a	s needed to report all pe	ersons).			
		and address of the agent, broker, o		commissi	ions or fees	were paid	
DIGITAL INSURANCE IN	С		LERIA PARKWY A, GA 30339				
(b) Amount of sales a	and base	Fees	and other commissions	paid			
commissions pa		(c) Amount	(d	(d) Purpose			(e) Organization code
	3694 571 FEES			3			
	(a) Name a	and address of the agent, broker, o	or other person to whom	commissi	ions or fees	were paid	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  JOEL N NEWMAN AGENCY LLC  12360 LAKE CITY WAY NE SEATTLE, WA 98125							
(b) Amount of sales a	and hase	Fees	and other commissions	paid			
commissions pa		(c) Amount	(d	l) Purpose	)		(e) Organization code
	1460	1082 FEI	ES				3

Schedule A (Form 5500) 2	017	Page <b>2</b> – 1		
(a) Name	19807	or other person to whom commissions or fees were paid 2ND DR SE ELL, WA 98012		
	F	Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount			
861	1458	FEES	3	
(a) Name	e and address of the agent, broker.	, or other person to whom commissions or fees were paid		
KATHLEEN COLLINS	1717 \$	SW HENDERSON ST TLE, WA 98106		
	F	ees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
1199	70	FEES	3	
(a) Name	e and address of the agent, broker,	or other person to whom commissions or fees were paid		
BRIAN T MURPHY LLC		17TH AVE SW FLE, WA 98136		
40.0	F	ees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
732	299	FEES	3	
(a) Name	e and address of the agent, broker,	or other person to whom commissions or fees were paid		
DANIEL PAEK	1709 S	SOUTH 87TH STREET MA, WA 98444		
40.0	F	ees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
503	316	FEES	3	
(a) Name	and address of the agent, broker	or other person to whom commissions or fees were paid	<u>'</u>	
KELSEY LAINE WATKINS	725 SF	PRUCE STREET INDS, WA 98020		

Fees and other commissions paid

(d) Purpose

(c) Amount

69

FEES

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

493

(e) Organization code

Page	2 –	2	

Schedule A (Form 5500)	2017	rage Z — Z	
		, or other person to whom commissions or fees were paid	
LAURABETH CHRISTENSEN		2ND DR SE ELL, WA 98012	
		,	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
143	366	FEES	3
		, or other person to whom commissions or fees were paid	
KRISTA MARIE HURLOCKER	2325 l #B	HOWARD AVE NE	
		ETT, WA 98203	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
399	, , , , , , , , , , , , , , , , , , ,	` ` `	3
<b>(a)</b> Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
NW BENEFITS GROUP LLC	3104 N	MCALLISTER ST	
	DUPO	NT, WA 98327	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	84	FEES	code 3
.00		. 220	
<b>(a)</b> Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
WHITFIELD BENEFIT SOLUTIONS	341 W	/. TUDOR ROAD	
	ANCH	ORAGE, AK 99503	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(a) 1 dipose	code 3
193			3
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
BRIAN RODERICK		MCALLISTER ST	
	DUPO	NT, WA 98327	
			(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

53 FEES

Schedule A	(Form 5	500)	2017

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Page <b>2</b> -	3	

(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
ZINA OSTER	3153	FOREST DR 'ENNE, WY 82001	
	Т		
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization code
19			3
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	l l
VENISA YOUNG		D PLACE SE JRN, WA 98002	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
17			3
	me and address of the agent, broker	r, 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> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	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)			
		\(\frac{1}{2} \)	( - /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

P	art	III	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual to the contract of the same the information may be combined for repor employees, the entire group of such individual to the contract of the contract of the contract to the contract of the contract of the contract to the contract covers the same the information may be combined for report employees, the entire group of such individual to the contract covers the contract covers the contract to the c	group	ip of purp	oses if	such cor	ntracts are	exp	erien	ce-rated a	as a uni	t. Where o	contract	s cover individu	
8	Ben	efit a	nd contract type (check all applicable boxes)	) _						_						
	а	X He	ealth (other than dental or vision)	b		Dental			С	Vis	sion			d	Life insurance	
	е	Te	mporary disability (accident and sickness)	f	L	ong-ter	rm disabi	lity	g	Su	pplementa	al unem	ployment	h	Prescription dr	ug
	i İ	Sto	op loss (large deductible)	ιĒ	Īμ	HMO cor	ntract		k	] PP	O contrac	:t		ıĦ	Indemnity cont	ract
	m		her (specify) DISABILITY, ACCIDENT, C	ANCI	_			IESS	<u> </u>	_					, , ,	
9	Ехр	erienc	ce-rated contracts:													
	а	Prem	iums: (1) Amount received					9a(1	)							
		(2) Ir	ncrease (decrease) in amount due but unpai	d				9a(2	2)							
		(3) Ir	ncrease (decrease) in unearned premium re-	serve	ð			9a(3	3)				1			
		(4) E	arned ((1) + (2) - (3))										. 9a(4)			(
	b		efit charges (1) Claims paid						_							
			ncrease (decrease) in claim reserves										1			
		(3) Ir	ncurred claims (add (1) and (2))										9b(3)			(
		` '	Claims charged										. 9b(4)			
	С		nainder of premium: (1) Retention charges (				,	- (1)	1	1						
			(A) Commissions													
			(B) Administrative service or other fees					0 (4)								
			(C) Other specific acquisition costs													
			(D) Other expenses					0. (4)								
			(E) Taxes(F) Charges for risks or other contingencies.											_		
			(G) Other retention charges				•••••	9c(1)(	(G)							
			(H) Total retention										9c(1)(H	ı)		(
			Dividends or retroactive rate refunds. (These				_		_					'		
	٦					,	ш		_							
	d		us of policyholder reserves at end of year: (	•			•						9d(1) 9d(2)			
		` '	Other reserves										9d(2)			
	е	` '	dends or retroactive rate refunds due. (Do r													
10			erience-rated contracts:	iot inc	ciuu	c arriou	in cinci	od III IIIIC .	JC( <u>Z)</u>	<i>j</i> .,			., 50			
. •	a		al premiums or subscription charges paid to	carrie	-r								. 10a			28348
	b		e carrier, service, or other organization incur										100			200 10
		rete	ntion of the contract or policy, other than rep										10b			
В		cify r	nature of costs.	orted		-aiti, III	ille 2 abC	ме, герог	i amic	ount.			. 100			
	art		Provision of Information													
11	Die	d the	insurance company fail to provide any inforr	nation	n ne	cessary	y to com	plete Sch	edule	e A?.			Yes	X N	0	
12	l If t	he ar	nswer to line 11 is "Yes," specify the information	tion n	not p	rovided	d. <b>•</b>									

### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security

## 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

2017

Administration	the mstruction	ons to the rollings						
Pension Benefit Guaranty Corporation				This Form is Open to Public Inspection				
Part I Annual Report Identifica	ation Information							
For calendar plan year 2017 or f scal plan ye		17	and ending 12/3	1/2017				
A This return/report is for:	ultiemployer 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 sin	ngle-employer plan	en der etternet i til i i etting betiden etting etting etting etting ettingen til i ettingen til i etting etti						
B This return/report is:	the first return/report							
This return report is:	mended return/report	a short plan year return/report (less than 12 months)						
C If the plan is a collectively-bargained plan	, check here							
D Check box if filing under:	5558	automatic exten	sion	the DFVC program				
	al extension (enter description)	_						
Part II Basic Plan Information-		21						
	enter all requested information	1		1h These disit slass				
1a Name of plan				1b Three-digit plan number (PN) ▶ 501				
SEATTLE INDIAN HEALTH BO INSURANCE PLAN	DARD MEDICAL, DENTA	L, LIFE/AD&I	& DISABILITY	1c Effective date of plan				
INSURANCE PLAN				01/01/1984				
2a Plan sponsor's name (employer, if for a	single-employer plan)			2b Employer Identification				
Mailing address (include room, apt., suit				Number (EIN)				
City or town, state or province, country,	and ZIP or foreign postal code	(if foreign, see instru	uctions)	91-0869056				
SEATTLE INDIAN HEALTH BO	ARD			2c Plan Sponsor's telephon				
				number				
				206-324-9360				
PO BOX 3364	611 1	2TH AVE S.		2d Business code (see instructions)				
				621399				
SEATTLE WA 9	8114-3364 SEATT	LE	WA 98144					
Caution: A penalty for the late or incompl	ete filing of this return/report	t will be assessed t	unless reasonable cause is	s established.				
Under penalties of perjury and other penalties	es set forth in the instructions, I	declare that I have	examined this return/report,	including accompanying schedules,				
statements and attachments, as well as the	electronic version of this return/	report, and to the be	est of my knowledge and be	lief, it is true, correct, and complete.				
M1.1 /1. 1000	1.7/1							
SIGN //	use	05/16/2018	PAM GRINDLEY					
HERE Simply of also additionates		Dete	Trice 2 On the Control of the Control of the	di- - -tt				
\$ignature of plan administrator		Date	Enter name of individual s	igning as plan administrator				
SIGN								
HERE								
Signature of employer/plan spo	nsor	Date	Enter name of individual s	igning as employer or plan sponsor				
SIGN								
HERE Signature of DFE		Data	Enter name of individual a	ionina ao DEE				
For Panaruark Reduction Act Nation and	Abo Instructions for Form 55	Date	Enter name of individual signing as DFE					

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2017) v. 170203

	Form 5500 (2017)	Pag	ge <b>2</b>		
3a	Plan administrator's name and address X Same as Plan Sponsor			3b Adn	ninistrator's EIN
		3c Administrator's telephone number			
4	If the name and/or EIN of the plan sponsor or the plan name has changed since other the plan sponsor's name, EIN, the plan name and the plan number from		4b EIN		
a c	Sponsor's name Plan Name	4d PN			
5	Total number of participants at the beginning of the plan year			5	176
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d).	complete only lines 6a(1),			
a(	1) Total number of active participants at the beginning of the plan year			6a(1)	176
a(	2) Total number of active participants at the end of the plan year			6a(2)	161
b	Retired or separated participants receiving benefits			. 6b	2
С	Other retired or separated participants entitled to future benefits			. 6с	0
d	Subtotal. Add lines 6a(2), 6b, and 6c.			. 6d	163
е	Deceased participants whose beneficiaries are receiving or are entitled to receiving	eive benefits.		. 6e	
f	Total. Add lines 6d and 6e		. 6f		
g	Number of participants with account balances as of the end of the plan year (complete this item)		. 6g		
h	Number of participants who 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 m				
b	If the plan provides pension benefits, enter the applicable pension feature code	es from the Lis	st of Plan Characteristics Code	es in the ir	nstructions:
9a	Plan funding arrangement (check all that apply)  (1) X Insurance	9b Plan be (1)	nefit arrangement (check all th	at apply)	
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3)	insuranc	e contracts
	(3) Trust	(3)	Trust		
	(4) X General assets of the sponsor	(4)	X General assets of the s	-	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at	tached, and, v	where indicated, enter the num	ber attacl	hed. (See instructions)
а	Pension Schedules	b Genera	al Schedules		
	(1) R (Retirement Plan Information)	(1)	H (Financial Infor		
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Inform		Small Plan)
	Purchase Plan Actuarial Information) - signed by the plan	(3)	A (Insurance Info	rmation)	
	actuary	(4)	C (Service Provid	der Inform	ation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	D (DFE/Participa	ting Plan	Information)
	Information) - signed by the plan actuary	(6)	G (Financial Tran	saction S	schedules)