## Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

# **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 instructi					
Pensio	n Benefit Guaranty Corporation					m is Open to Pเ Inspection	ıplic
Part I		dentification Information					
For caler	ndar plan year 2017 or fisc	cal plan year beginning 01/01/2017		and ending 12/31/20	)17		
A This r	eturn/report is for:	a multiemployer plan	_ participating er	loyer plan (Filers checking the mployer information in accordance)			ns.)
		a single-employer plan	a DFE (specify	)			
<b>B</b> This r	eturn/report is:	the first return/report	the final return	report/report/			
	·	an amended return/report	a short plan ye	ar return/report (less than 12	2 months)		
C If the	plan is a collectively-barg	ained plan, check here				]	
<b>D</b> Check	k box if filing under:	Form 5558	automatic exten	sion	the DF	VC program	
		special extension (enter description)	_		_		
Part II	Basic Plan Infor	mation—enter all requested informatio	n				
	e of plan EER HOLDINGS, INC. E	MPLOYEE BENEFIT PLAN				ree-digit plan mber (PN) ▶	501
						ective date of pla /01/2014	an
Maili City	ng address (include room or town, state or province	er, if for a single-employer plan) n, apt., suite no. and street, or P.O. Box) r, country, and ZIP or foreign postal code	(if foreign, see instru	uctions)	Nu	nployer Identifica mber (EIN) -3561660	ition
PRIVATE	ER HOLDINGS, INC.					an Sponsor's tele mber 206-453-0766	•
	STLAKE AVE E E, WA 98102	1920 EASTLAKE AVE E SEATTLE, WA 98102			ins	siness code (see tructions) 1112	Э
Caution:	A penalty for the late o	r incomplete filing of this return/repor	t will be assessed u	unless reasonable cause is	s established	i.	
		er penalties set forth in the instructions, I rell as the electronic version of this return					
21211							
SIGN HERE	Filed with authorized/valid	d electronic signature.	06/05/2018	MISTY BENDER			
	Signature of plan admi	inistrator	Date	Enter name of individual signing as plan administrator			
SIGN HERE							
HEKE	Signature of employer	/plan sponsor	Date	Enter name of individual si	igning as emp	oloyer or plan sp	onsor
SIGN							

Date

**HERE** 

Signature of DFE

Enter name of individual signing as DFE

	Form 5500 (2017)	Pa	age <b>2</b>			
3a	Plan administrator's name and address Same as Plan Sponsor				<b>3b</b> Administra	
PR	IVATEER HOLDINGS, INC.					ator's telephone
	20 EASTLAKE AVE E ATTLE, WA 98102				number	53-0766
4	If the name and/or EIN of the plan sponsor or the plan name has changed si enter the plan sponsor's name, EIN, the plan name and the plan number from			ed for this plan,	4b EIN	
а	Sponsor's name	in the last reta	питороп.		4d PN	
С	Plan Name					
5	Total number of participants at the beginning of the plan year				5	154
6	Number of participants as of the end of the plan year unless otherwise states <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).	d (welfare plar	is complete o	nly lines <b>6a(1)</b> ,		
a(	1) Total number of active participants at the beginning of the plan year				. 6a(1)	154
a(	2) Total number of active participants at the end of the plan year				. 6a(2)	191
b	Retired or separated participants receiving benefits				. 6b	11
С	Other retired or separated participants entitled to future benefits				6c	40
d	Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b>				6d	242
_						
e	Deceased participants whose beneficiaries are receiving or are entitled to re					0.40
Ť	Total. Add lines <b>6d</b> and <b>6e</b>				. 6f	242
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 wit less than 100% vested				6h	
7	Enter the total number of employers obligated to contribute to the plan (only				7	
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from the l	ist of Plan C	haracteristics Code	es in the instruc	tions:
b	If the plan provides welfare benefits, enter the applicable welfare feature coo 4A 4D 4E 4B 4F 4H 4Q	des from the Li	st of Plan Ch	aracteristics Codes	s in the instruction	ons:
9a	Plan funding arrangement (check all that apply)			ement (check all the	at apply)	
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) (2)	X Insur Code	section 412(e)(3)	insurance contr	acts
	(3) Trust	(3)	Trust	. , . ,		
40	(4) General assets of the sponsor	(4)		ral assets of the sp		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a				oer attached. (S	see instructions)
а	Pension Schedules		al Schedule:		(')	
	(1) R (Retirement Plan Information)	(1) (2)	H	H (Financial Inform	,	llan)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	H	(Financial Inform		iaii)
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3)	H	A (Insurance Infor	,	
	,	(4) (5)	H	C (Service Provide	,	ution)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) (6)		<ul><li>D (DFE/Participati</li><li>G (Financial Trans</li></ul>	-	

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017								
A Name of plan PRIVATEER HOLDINGS, INC. EMPLOYEE BENEFIT PLAN				e-digit number (PN)	501			
•	sor's name as HOLDINGS, II		e 2a of Form 5500			yer Identification Number 3561660	(EIN)	
Part I	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:							
` '	insurance carri IFE INSURANC		Y OF AMERICA					
(b) E	≣IN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a		_	ontract year	
(0)		code	identification number	policy or contrac		(f) From	<b>(g)</b> To	
13-5123390	6	64246	515917	224	ļ	01/01/2017	12/31/2017	
	fee and commi		tion. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents, brokers, and c	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
			18781				0	
3 Persons re	eceiving comm		es. (Complete as many entries					
C2 CENTRIC		(a) Name a	nd address of the agent, broker, PO BO		m commiss	ions or fees were paid		
CZ CENTRIC				O RAPIDS, MI 49516				
(h) Amoui	nt of sales and	hase	Fee	s and other commission	ns paid			
	missions paid	5400	(c) Amount	(d) Purpose		e	(e) Organization code	
		66	0				3	
		(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees were naid		
THE PARTNE	RS GROUP	(a) Hamo ai	11740	SW 68TH PKWY, STE : AND, OR 97223		ione of 1000 Word para		
(b) Amount of sales and base Fees and other commiss		s and other commission	ns paid					
	missions paid		(c) Amount		(d) Purpos	e	(e) Organization code	
15558 0						3		
For Paperwork Reduction Act Notice, see the Instructions for Form 5500.  Schedule A (Form 5500) 2017 v. 170203								

Cohodulo A (Form FF00)	2047	Daws 2	
Schedule A (Form 5500)	2017	Page <b>2 –</b> 1	
(a) Nam	e and address of the agent, brok	er, or other person to whom commissions or fees were paid	d
DAILYFEATS INC	131 BOS	TREMONT ST, 3RD FLOOR STON, MA 02111	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
3157		0	3
(a) Nam	e and address of the agent, brok	ter, or other person to whom commissions or fees were paid	1
(h) Amount of color and have		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nam	e and address of the agent, brok	er, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nam	e and address of the agent, brok	er, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(c) Amount

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

Fees and other commissions paid

(d) Purpose

(e) Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I 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 er			5	
		tracts With Allocated Funds:				
-	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 cor				
	<u>.</u>	retention 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) other (specify)				
	_			. $\Box$		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	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)			
		<b>•</b>				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

ı	Page	4

F	Part	III	Welfare Benefit Contract Information from the information may be combined for report employees, the entire group of such individuals.	group of employees of the ting purposes if such cont	racts are exp	erience-rated as a uni	it. Where co	ontracts cover in	
8	Ben	efit a	nd contract type (check all applicable boxes)						
Ī	a [	_	ealth (other than dental or vision)	<b>b</b> Dental	сГ	Vision		<b>d</b> X Life insur	ance
	L			<b>=</b>	_			_	
	e	_	mporary disability (accident and sickness)	- H	·		ipioyment	h ∐ Prescripti	•
	ا ا	Sto	op loss (large deductible)	j  HMO contract	K L	PPO contract		I Indemnity	contract
	m	X Ot	her (specify) ►ACCIDENTAL DEATH AND	DISMEMBERMENT					
9	•		ce-rated contracts:						
	а		iums: (1) Amount received						
			ncrease (decrease) in amount due but unpaid						
			ncrease (decrease) in unearned premium res				00(4)		
	h	. ,	farned ((1) + (2) - (3))				. 9a(4)		
	b		efit charges (1) Claims paid ncrease (decrease) in claim reserves						
			ncurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)		
			Claims charged				9b(4)		
	С	` '	nainder of premium: (1) Retention charges (c		•••••		05(+)		
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees						
			(C) Other specific acquisition costs		0 (4)(0)				
		(	(D) Other expenses		9c(1)(D)				
		(	(E) Taxes						
		(	(F) Charges for risks or other contingencies.						
			(G) Other retention charges		9c(1)(G)				
			(H) Total retention	_	_		. 9c(1)(H	)	
		(2) [	Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)		
	d	Stat	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	r retirement	• •		
		` '	Claim reserves				. 9d(2)		
	_	` '	Other reserves						
41			dends or retroactive rate refunds due. (Do n	ot include amount entered	d in line <b>9c(2)</b>	<b>)</b> .)	9e		
10	_		erience-rated contracts:				100		405046
	a		Il premiums or subscription charges paid to c				. <u>10a</u>		105242
	b Sne	rete	e carrier, service, or other organization incuring of the contract or policy, other than replature of costs.				10b		
			ature of costs.						
F	art	IV	Provision of Information						
11	<b>l</b> Dic	the	insurance company fail to provide any inform	nation necessary to comp	lete Schedule	e A?	Yes	X No	
12	<b>2</b> If t	he ar	swer 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

				Inspection				
For calendar plan year 20°	7 or fiscal plar	n year beginning 01/01/2017		and en	ding 12/3	1/2017		
A Name of plan PRIVATEER HOLDINGS,	INC. EMPLOY	YEE BENEFIT PLAN		B Three-digit plan number (PN) ▶		501		
C Plan sponsor's name a PRIVATEER HOLDINGS,		e 2a of Form 5500			yer Identifica 3561660	ation Number (	EIN)	
		rning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance car UNITED HEALTHCARE IN		DMPANY						
4.5 = 15.1	(c) NAIC	(d) Contract or	(e) Approximate nui			Policy or co	contract year	
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To	
36-2739571	79413	904844	380		01/01/2017	7	12/31/2017	
2 Insurance fee and commodescending order of the		ation. Enter the total fees and tota	l commissions paid. Lis	st in line 3	the agents, l	brokers, and ot	her persons in	
(a) Total a	mount of comi			<b>(b)</b> To	otal amount o	of fees paid		
		104307					27433	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all p	ersons).				
	(a) Name a	and address of the agent, broker, o	•		ions or fees	were paid		
THE PARTNERS GROUP			SW 68TH PKWY, STE 2 AND, OR 97223	00				
(b) Amount of sales an	d base	Fees	s and other commission	s paid				
commissions pai		(c) Amount	(d) Purpose				(e) Organization code	
	104307	27433 BO	DNUS				3	
	(a) Name a	and address of the agent, broker, o	or other person to whom	n commiss	ions or fees	were paid		
(b) Amount of sales an	d base	Fees	s and other commission	s paid				
commissions pai		(c) Amount		d) Purpose	e		(e) Organization code	
For Paperwork Reduction	n Act Notice,	see the Instructions for Form 55	500.			Sched	lule A (Form 5500) 2017	

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees 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		
<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 individual this report.	dual contrac	cts with each carrier may	be treated	I 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 er			5	
		tracts With Allocated Funds:				
-	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 cor				
	<u>.</u>	retention 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) other (specify)				
	_			. $\Box$		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	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)			
		<b>•</b>				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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P	art I	III Welfare Benefit Contract Informa	tion					
		If more than one contract covers the same of the information may be combined for reportional employees, the entire group of such individual.	ng purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ontracts cover in	
8	Bene	efit and contract type (check all applicable boxes)		-	<u> </u>	-		
	a 🔀	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insu	rance
	<u> </u>	Temporary disability (accident and sickness)	f Long-term disabilit	<u> </u>	<u></u>	nlovmont	h Prescript	
	e		<u></u>	· - =	Supplemental unem	pioyinent	=	_
	י וַ	Stop loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnit	y contract
	m	Other (specify)						
9	Expe	erience-rated contracts:	1					
		Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium reso	· ·	9a(3)				
	_	(4) Earned ((1) + (2) - (3))				9a(4)		
		Benefit charges (1) Claims paid		(-)				
		(2) Increase (decrease) in claim reserves	· ·			01 (0)		
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (or	·	0-(4)(A)				
		(A) Commissions		9c(1)(A)			_	
		(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)				
		(C) Other specific acquisition costs		9c(1)(D)				
		(D) Other expenses(E) Taxes						
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention	•			9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These					'	
	d	Status of policyholder reserves at end of year: (1)	_	_		9d(1)		
	u	(2) Claim reserves	•			9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no						
10		nexperience-rated contracts:			,	1		
		Total premiums or subscription charges paid to ca	arrier			10a		2085284
	_	If the carrier, service, or other organization incurre						
		retention of the contract or policy, other than repo	, ,		•	. 10b		
	Spe	cify nature of costs.						
_								
	art I						<b>—</b>	
11	Did	the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	X No	
12	If 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

OMB No. 1210-0110

2017

					Inspection			
For calendar plan year 20°	17 or fiscal plar	n year beginning 01/01/2017		and en	nding 12/3	1/2017		
A Name of plan PRIVATEER HOLDINGS,	INC. EMPLOY	EE BENEFIT PLAN		B Three-digit plan number (PN) ▶			501	
·	C Plan sponsor's name as shown on line 2a of Form 5500  PRIVATEER HOLDINGS, INC.  D Employer Identification Number (EI 45-3561660					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 car VISION SERVICE PLAN	rrier							
/L\	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year	
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To	
23-7089668	53031	30064675	213	3	01/01/201	7	12/31/2017	
2 Insurance fee and compute descending order of the		ation. Enter the total fees and tota	al 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			of fees paid					
		1089					0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	sions or fees	were paid		
THE PARTNERS GROUP			SW 68TH PKWY, STE : AND, OR 97223	200				
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code	
	1089	0				3		
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	sions or fees	were paid		
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code	
For Donomicals Doductio	n Act Natice	see the Instructions for Form F	500			Cabaa	Iula A /Farm FEOO) 2017	

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
Fees and other commissions paid					
(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		
<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 paid			(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 individual this report.	dual contrac	cts with each carrier may	be treated	I 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 er			5	
		tracts With Allocated Funds:				
-	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 cor				
	<u>.</u>	retention 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) other (specify)				
	_			, n		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	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)			
		<b>•</b>				
		•				
					_ (=)	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

ı	Page	4

F	art	III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individuals.	group of employees of the ting purposes if such conti	racts are expe	erience-rated as a unit	. Where co	ontracts cover individ	
8	Rene	ofit a	nd contract type (check all applicable boxes)		arrior may be t	ireated as a drift for pe	arposco or 1	ино тороги.	
Ü		_	, , , , , , , , , , , , , , , , , , , ,	<b>b</b> Dental	c 🔽	Vision		<b>d</b> Life insurance	•
	a [	=	alth (other than dental or vision)	<u>.</u>	=	Vision		_	
	е	Те	mporary disability (accident and sickness)	f Long-term disabilit	· ' <u>-</u>	Supplemental unemp	ployment	h Prescription	•
	i	Sto	op loss (large deductible)	j HMO contract	k _	PPO contract		I Indemnity co	ntract
	m	Ot	her (specify)						
	_								
9	Ехре	eriend	ce-rated contracts:						
	а	Prem	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpai	t					
			ncrease (decrease) in unearned premium res						
	_		arned ((1) + (2) - (3))				9a(4)		
			efit charges (1) Claims paid						
			ncrease (decrease) in claim reserves				01 (0)		
			ncurred claims (add (1) and (2))				9b(3)		
		` '	claims charged(1) Patentian sharges (				9b(4)		
	С		nainder of premium: (1) Retention charges (c		9c(1)(A)				
			A) Commissions B) Administrative service or other fees						
			C) Other specific acquisition costs		0.74770				
			D) Other expenses		0 (4)(D)				
			E) Taxes		9c(1)(E)				
			(F) Charges for risks or other contingencies.						
		(	G) Other retention charges		9c(1)(G)				
			(H) Total retention				9c(1)(H	)	
		(2) [	Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Stat	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) (	Claim reserves				9d(2)		
		(3) (	Other reserves				9d(3)		
			dends or retroactive rate refunds due. (Do n	ot include amount entered	I in line 9c(2).	)	. 9e		
10	) No	nexp	erience-rated contracts:						
	а	Tota	I premiums or subscription charges paid to o	arrier			10a		19498
	b	rete	e carrier, service, or other organization incurnation of the contract or policy, other than reporture of costs				. 10b		
P	Spe		Provision of Information						
					ata Calcollel	Λο Π	Yes	X No	
11			insurance company fail to provide any inforn		ete Schedule	A?	res	NO NO	
12	. If th	ne an	swer 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

			RISA section 103(a)(2).	morman	OII	This For	m is Open to Public Inspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and end	ding 12/3	31/2017	•
A Name of plan PRIVATEER HOLDINGS	, INC. EMPLO	YEE BENEFIT PLAN	В		e-digit number (PN	N) <b>•</b>	501
C Plan sponsor's name a PRIVATEER HOLDINGS,		e 2a of Form 5500	D		yer Identific 3561660	ation Number	(EIN)
		rning Insurance Contract  A. Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca DELTA DENTAL OF WASI							
# N = N .	(c) NAIC	(d) Contract or	(e) Approximate numb	-		Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered at en policy or contract ye		(f)	From	<b>(g)</b> To
91-0621480	47341	12700	215		01/01/201	7	12/31/2017
2 Insurance fee and come descending order of the		ation. Enter the total fees and total	al commissions paid. List in	n line 3 t	he agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid				<b>(b)</b> To	tal amount	of fees paid	
	9425 0						
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all per	sons).			
	(a) Name a	and address of the agent, broker,	or other person to whom co	ommissi	ons or fees	were paid	
THE PARTNERS GROUP			SW 68TH PKWY, STE 200 AND, OR 97223				
(b) Amount of sales ar	nd base _	Fee	s and other commissions p	aid			
commissions pai		(c) Amount	(d)	Purpose	1		(e) Organization code
	9425	0					3
	(a) Name a	and address of the agent, broker,	or other person to whom co	ommissi	ons or fees	were paid	
(b) Amount of sales ar	nd base	Fee	s and other commissions p	aid			
commissions pai		(c) Amount	(d)	Purpose			(e) Organization code
E B 1.D. 1. °	- A-1 N -1		500				A. J. A (F 5500) 05:-
For Paperwork Reductio	n ACT NOTICE	see the Instructions for Form 5	500.			Scher	dule A (Form 5500) 2017

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
Fees and other commissions paid					
(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		
<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 paid			(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 individual this report.	dual contrac	cts with each carrier may	be treated	I 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 er			5	
		tracts With Allocated Funds:				
-	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 cor				
	<u>.</u>	retention 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) other (specify)				
	_			, n		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	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)			
		<b>•</b>				
		•				
					_ (=)	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

Page	Δ
Page	4

F	art	Welfare Benefit Contract Information	ation					
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individual.	ting purposes if such cont	racts are exp	perience-rated as a ur	nit. Where co	ontracts o	cover individual
8	Ben	efit and contract type (check all applicable boxes)						-
	а	Health (other than dental or vision)	<b>b</b> X Dental	с	Vision		<b>d</b> ∏ Li	fe insurance
	e	Temporary disability (accident and sickness)	f Long-term disability	<u> </u>	Supplemental uner	nnlovmont	=	rescription drug
	: [			- 5		пріоуппені		
	'	Stop loss (large deductible)	j  HMO contract	ĸ	PPO contract		I ∐ In	demnity contract
	m	Other (specify)						
_								
9		erience-rated contracts:			1			
		Premiums: (1) Amount received		9a(1)		200644	_	
		(2) Increase (decrease) in amount due but unpaid				0		
		(3) Increase (decrease) in unearned premium res				0-(4)	)	200644
	h	(4) Earned ((1) + (2) - (3))				<b>9a(4)</b> 122455		200644
	b	Benefit charges (1) Claims paid		(-)		20001		
		(3) Incurred claims (add (1) and (2))						142456
		(4) Claims charged				9b(4)		124456
	С	Remainder of premium: (1) Retention charges (c				55(1)		
		(A) Commissions	,	9c(1)(A)		9425	5	
		(B) Administrative service or other fees		9c(1)(B)		28670		
		(C) Other specific acquisition costs		9c(1)(C)		(	)	
		(D) Other expenses		9c(1)(D)		C	)	
		(E) Taxes		9c(1)(E)		C	)	
		(F) Charges for risks or other contingencies.				C	)	
		(G) Other retention charges		9c(1)(G)		C	)	
		(H) Total retention					)	38095
		(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						
		(2) Claim reserves						4000
		(3) Other reserves				• • •		
4.		Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line <b>9c(2</b>	<b>)</b> .)	9e		
10	_	nexperience-rated contracts:				40-		
	а	Total premiums or subscription charges paid to o				<u>10a</u>		
	b	If the carrier, service, or other organization incurrent and the contract or policy other than rep			•	10b		
	Spe	retention of the contract or policy, other than rep- cify nature of costs.	onted in Part I, line 2 abov	e, report am	ount			
	Opo	sily matare or ecolor						
P	art	V Provision of Information						
11		I the insurance company fail to provide any inform	nation necessary to comp	ete Schedule	e A?	Yes	X No	
		ne answer to line 11 is "Yes," specify the informat	•	2.0 201100011		1		
1 4	- 11 (1	io anomor to into 11 to 100, opening the initititat	ion not provided.					

#### 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 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

This Form is Open to Public Inspection

Part I Annual Report I	dentification Information						
For calendar plan year 2017 or fis	cal plan year beginning 01/01/2017	and ending 12/31/2017	7				
<b>A</b> This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking this participating employer information in accorda			ns.)		
	a single-employer plan	a DFE (specify)					
<b>B</b> This return/report is:	the first return/report	the final return/report					
	an amended return/report	a short plan year return/report (less than 12 n	nonths	)			
C If the plan is a collectively-barg	gained plan, check here			<b>•</b> [			
<b>D</b> Check box if filing under:	Form 5558	automatic extension	th	e DFVC program			
	special extension (enter description	n)					
Part II Basic Plan Infor	Part II Basic Plan Information—enter all requested information						
1a Name of plan PRIVATEER HOLDINGS, INC. E			1b	Three-digit plan number (PN) ▶	501		
			1c	Effective date of pla 01/01/2014	an		
	ver, if for a single-employer plan) n, apt., suite no. and street, or P.O. Box) e, country, and ZIP or foreign postal code		2b	Employer Identification Number (EIN) 45-3561660			
PRIVATEER HOLDINGS, INC.			2c	Plan Sponsor's tele number 206-453-0766	phone		
1920 EASTLAKE AVE E SEATTLE, WA 98102		STLAKE AVE E , WA 98102	2d	Business code (see instructions) 551112	)		

#### Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties 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 best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Rommie Callaghan	06/05/2018	Rommie Callaghan
HENE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Rommie Callaghan	06/05/2018	Rommie Callaghan
HENE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2017) v. 170203