## 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 instructions to the Form 5500.							
Pensio	on Benefit Guaranty Corporation				This Form is Open to Public Inspection		blic		
Part I	Annual Report Ide	ntification Information							
For cale	ndar plan year 2017 or fiscal	plan year beginning 01/01/2017		and ending 12/31/20	)17				
<b>A</b> This	return/report is for:	a multiemployer plan		loyer plan (Filers checking the modern the moder information in accortication accortication in accortication in accortication in accortication			ns.)		
		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)				
C If the	plan is a collectively-bargain	ned plan, check here							
<b>D</b> Chec	k box if filing under:	Form 5558	automatic exten	sion	the	DFVC program			
	Ī	special extension (enter description)	_		_				
Part II	Basic Plan Inform	ation—enter all requested informatio	n						
	ne of plan	ation—enter all requested informatio	11		1h	Three-digit plan			
	N & SONS HEALTH INSUR.	ANCE PLAN				number (PN) ▶	501		
						Effective date of pla 01/01/2008	an .		
Mail City	ing address (include room, a or town, state or province, c	if for a single-employer plan) apt., suite no. and street, or P.O. Box) ountry, and ZIP or foreign postal code	(if foreign, see instru	uctions)	2b Employer Identification Number (EIN) 91-1726988		tion		
NELSON	I & SONS CONSTRUCTION	CO., INC			2c Plan Sponsor's telephone number 360-668-3800		phone		
P.O. BOX WOODIN	X 228 IVILLE, WA 98072	21820 87TH AVENUE SE WOODINVILLE, WA 98072				Business code (see instructions) 237990	;		
Caution	: A penalty for the late or in	ncomplete filing of this return/repor	t will be assessed ι	unless reasonable cause is	s establisl	hed.			
		penalties set forth in the instructions, I as the electronic version of this return							
		1							
SIGN HERE	Filed with authorized/valid e	lectronic signature.	07/19/2018	SHARON HANDRAN					
HERE	Signature of plan admini	strator	Date	Enter name of individual si	igning as p	olan administrator			
SIGN									

Date

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

Signature of employer/plan sponsor

Signature of DFE

**HERE** 

SIGN HERE

> Form 5500 (2017) v. 170203

Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

	Form 5500 (2017)	Pa	age <b>2</b>			
3a	Plan administrator's name and address X Same as Plan Sponsor			3b Administra		
				number		
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin enter 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	150	
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 plan	ns complete only lines 6a(1),			
а(	1) Total number of active participants at the beginning of the plan year			. 6a(1)	155	
a(	2) Total number of active participants at the end of the plan year			6a(2)	158	
b	Retired or separated participants receiving benefits			6b	0	
С	Other retired or separated participants entitled to future benefits			6c	0	
d	Subtotal. Add lines 6a(2), 6b, and 6c			6d	158	
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits.		6e		
f	Total. Add lines <b>6d</b> and <b>6e</b> .			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			. 7		
8a b	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:  If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  4A 4B 4D 4F 4L 4Q					
9a	Plan funding arrangement (check all that apply)  (1)		enefit arrangement (check all th	at apply)		
	(1) Insurance (2) Code section 412(e)(3) insurance contracts	(1) (2)	Code section 412(e)(3)	insurance contra	ıcts	
	(3) Trust	(3)	Trust			
40	(4) General assets of the sponsor	(4)	General assets of the s			
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at	ttached, and,	where indicated, enter the num	ber attached. (S	ee instructions)	
а	Pension Schedules		al Schedules	(')		
	(1) R (Retirement Plan Information)	(1)	H (Financial Inform	,		
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Inform		an)	
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3)	X 4 A (Insurance Info	,		
	actually	(4)	C (Service Provid	er miormation)		

(5)

(6)

**SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

(3)

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

**G** (Financial Transaction Schedules)

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

This Form is Open to Public

pursuant to ERISA section 103(a)(2). Inspection					Inspection		
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	ding 12/3	1/2017	
A Name of plan NELSON & SONS HEAL	TH INSURANC	E PLAN		B Three	e-digit number (PN	N) <b>•</b>	501
C Plan sponsor's name a NELSON & SONS CONS					yer Identific 1726988	ation Number (	EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		DF WASHINGTON OPTIONS, INC	C.				
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To
91-1467158	47055	6628500	247		01/01/2017	7	12/31/2017
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	Il commissions paid. Lis	st in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comr			<b>(b)</b> To	tal amount	of fees paid	
		43099					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all p	ersons).			
		nd address of the agent, broker, o		n commiss	ions or fees	were paid	
DIGITAL INSURANCE INC		STE 199	LLERIA PKWY 50 FA, GA 30339				
(b) Amount of sales ar	nd base	Fees	s and other commission	s paid			
commissions pa		(c) Amount	(	d) Purpose	Э		(e) Organization code
43099						3	
	(a) Name a	nd address of the agent, broker,	or other person to whon	n commiss	ions or fees	were paid	
		<u>.</u>				·	
(b) Amount of sales ar	nd base	Fees	s and other commission	s paid			
commissions pa		(c) Amount	(	d) Purpose	9		(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 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	((	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 individual contracts with each carrier may be treated as a unit for purposes of this report.						
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	li ti	Welfare Benefit Contract Information one contract covers the same the information may be combined for report mployees, the entire group of such individual.	group of employees of the ting purposes if such cont	racts are expe	erience-rated as a unit	. Where co	ontracts cover individual
8	Ben		contract type (check all applicable boxes)					
-	a	_	th (other than dental or vision)	<b>b</b> Dental	с□	Vision		<b>d</b> Life insurance
	 F	_		<u>.</u>		ļ.		_
	e	=	porary disability (accident and sickness)	f Long-term disabili	· ~ \	Supplemental unemp	pioyment	h Prescription drug
	'	Stop	loss (large deductible)	j  HMO contract	k 📗	PPO contract		I Indemnity contract
	m	Othe	er (specify)					
9	•		rated contracts:					
	a I		ms: (1) Amount received		9a(1)			
			rease (decrease) in amount due but unpai					
			rease (decrease) in unearned premium res				0-(4)	
	h		rned ((1) + (2) - (3))				9a(4)	0
	b		t charges (1) Claims paid					
			rease (decrease) in claim reserves urred claims (add (1) and (2))				9b(3)	0
			ims charged				9b(4)	
	С	` '	nder of premium: (1) Retention charges (c		•••••		<u> </u>	
	·		Commissions	·	9c(1)(A)			
		` '	Administrative service or other fees					
			Other specific acquisition costs		0 (4)(0)			
		` '	Other expenses		0 (4)(D)			
		(E)	Taxes		9c(1)(E)			
		(F)	Charges for risks or other contingencies.		9c(1)(F)			
		(G	) Other retention charges		9c(1)(G)		_	
			Total retention				9c(1)(H)	0
		(2) Div	ridends or retroactive rate refunds. (These	e amounts were 📗 paid in	cash, or	credited.)	9c(2)	
	d	Status	of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)	
		(2) Cla	im reserves				9d(2)	
		` '	ner reserves				9d(3)	
			nds or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2).	<u>)</u>	. 9e	
10	) No		ence-rated contracts:					
	а		premiums or subscription charges paid to o				10a	851312
	b Sne	retenti	carrier, service, or other organization incur on of the contract or policy, other than rep				. 10b	
		cify nat	ure of costs.					
P	art l		Provision of Information					_
11	Dic	the ins	surance company fail to provide any inforn	nation necessary to compl	ete Schedule	A?	Yes	X No
12	2 If th	he ansv	ver 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	17 or fiscal plan	year beginning 01/01/2017		and en	ding 12/3	1/2017	
A Name of plan NELSON & SONS HEAL	TH INSURANCI	E PLAN		B Three-digit plan number (PN) 501			501
C Plan sponsor's name a NELSON & SONS CONS				-	oyer Identific 1726988	ation Number (	EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca							
/L) FIN	(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 contrac		(f)	From	<b>(g)</b> To
91-0621480	47341	10537	218	3	01/01/201	7	12/31/2017
2 Insurance fee and composite descending order of the		ation. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comn			<b>(b)</b> To	otal amount	of fees paid	
		5417					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
DIGITAL INSURANCE INC	C. ANDONIAN		OLLOCHET DRIVE NV RBOR, WA 98335	V			
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
	5417						3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions 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
Fan Damamuanlı Danlıyatla	n Ast Nation	see the Instructions for Form F	F00			Cabaa	Iula A (Farm FEOO) 2017

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 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	((	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 individual contracts with each carrier may be treated as a unit for purposes of this report.						
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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Р	art	III Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reportir	roup of employees of the					
		employees, the entire group of such individu	al contracts with each ca	rrier may be	treated as a unit fo	or purposes of the	his report.	
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> Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	y <b>g</b>	Supplemental un	nemployment	<b>h</b> Prescription drug	
	i [	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)	<i>•</i> ⊔	<u>L</u>	_		L ,	
	L							
9	Fxpe	erience-rated contracts:						
_		Premiums: (1) Amount received		9a(1)		108579		
		(2) Increase (decrease) in amount due but unpaid	-	9a(2)		0		
		(3) Increase (decrease) in unearned premium rese	_	9a(3)		0		
		(4) Earned ((1) + (2) - (3))	_			9a(4)	108	579
	b	Benefit charges (1) Claims paid		9b(1)		88900		
		(2) Increase (decrease) in claim reserves		9b(2)		-2000		
		(3) Incurred claims (add (1) and (2))				9b(3)	86	900
		(4) Claims charged				9b(4)	86	900
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)					
		(A) Commissions	<u></u>	9c(1)(A)		5417	<u>,                                     </u>	
		(B) Administrative service or other fees		9c(1)(B)		15105	<u> </u>	
		(C) Other specific acquisition costs		9c(1)(C)		0		
		(D) Other expenses	-	9c(1)(D)		0		
		(E) Taxes	F	9c(1)(E)		0		
		(F) Charges for risks or other contingencies	F	9c(1)(F)		0		
		(G) Other retention charges	_	9c(1)(G)		0 (4)(1)		VE 01
		(H) Total retention	_				20	)522
	_	(2) Dividends or retroactive rate refunds. (These						
	d	Status of policyholder reserves at end of year: (1)	·			· · · ·	_	
		(2) Claim reserves					3	3000
	_	(3) Other reserves						
40	e	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2)	<u>).)</u>	9e		
IU	_	nexperience-rated contracts:	2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4			100		_
	a	Total premiums or subscription charges paid to ca						
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than report						
	Spe	ecify nature of costs.	ited in Fait i, line 2 above	e, report ann	ount			
		,						
Р	art I	IV Provision of Information						
11		d the insurance company fail to provide any informa	ation necessary to comple	ete Schedule	e A?	Yes	X No	
		he answer to line 11 is "Yes," specify the information		or our leading	o / 1:	□	<u> </u>	
1 4	. 11 (1	he answer to line it is ites, specify the information	ni noi provided. 🔻					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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OMB No. 1210-0110

2017

		pursuant to E	RISA section 103(a)(2)	).			Inspection
For calendar plan year 20°	17 or fiscal plar	n year beginning 01/01/2017		and en	ding 12/3	1/2017	
A Name of plan NELSON & SONS HEALT	TH INSURANC	E PLAN			e-digit number (PI	N) <b>•</b>	501
C Plan sponsor's name a NELSON & SONS CONS				-	oyer Identific 1726988	ation Number (	EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance car WILLAMETTE DENTAL OF		DN, INC.					
/L\	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
91-1702099	47050	WA531	22	2	01/01/201	7	12/31/2017
2 Insurance fee and compute descending order of the		ation. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comr			<b>(b)</b> To	otal amount	of fees paid	
		931					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,			ions or fees	were paid	
DIGITAL INSURANCE, INC	O.		OLLOCHET DRIVE N\ RBOR, WA 98335	N			
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code
	931						3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code
For Donomicouls Doductio	n Act Notice	see the Instructions for Form F	E00			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	
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

ı	Page	4

P	art I	If more than one contract covers the same of the information may be combined for reporting the combine	roup of employees of the ng purposes if such cont	racts are e	xperience-rated as	s a unit. Where cor	ntracts cover individual
		employees, the entire group of such individu	al contracts with each ca	arrier may b	e treated as a uni	it for purposes of th	nis report.
8	Bene	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> X Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabili	tv <b>a</b>	Supplemental	unemployment	h Prescription drug
	i F	Stop loss (large deductible)	j HMO contract		PPO contract		I Indemnity contract
	· _		, Livio contract	•			I I Indominity contract
	m	Other (specify)					
_	_						
9		rience-rated contracts:		0-(4)		44000	
		Premiums: (1) Amount received		9a(1)		11639	_
		(2) Increase (decrease) in amount due but unpaid				0	_
		(3) Increase (decrease) in unearned premium rese				00(4)	11639
		(4) Earned ((1) + (2) - (3))				<b>9a(4)</b>	11038
		Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves				0b(2)	4928
		(3) Incurred claims (add (1) and (2))				9b(3) 9b(4)	4928
		(4) Claims charged				9D(4 <i>)</i>	4020
	С			9c(1)(A)		931	
		(A) Commissions(B) Administrative service or other fees		9c(1)(B)		1455	
		(C) Other specific acquisition costs		0 (4)(0)		0	
		(D) Other expenses		0 (4)(D)	_	0	
		(E) Taxes		a (4)(=)	_	175	
		(F) Charges for risks or other contingencies			_	0	
		(G) Other retention charges				0	
		(H) Total retention			•		2561
		(2) Dividends or retroactive rate refunds. (These	_	_	=		(
		Status of policyholder reserves at end of year: (1)	<b>—</b>		_		
	u	(2) Claim reserves	·			· · · · · ·	
		(3) Other reserves				2.1(2)	
	е	Dividends or retroactive rate refunds due. (Do no					
10		nexperience-rated contracts:	t moidae amount entered	2 111 11110 <b>30</b> (	<b>(~)</b> -,,		
		Total premiums or subscription charges paid to ca	arrier			10a	
	_	If the carrier, service, or other organization incurre					
	b	retention of the contract or policy, other than repo					
	Spec	cify nature of costs.		o, . op o a.		1930	I
P	art l	V Provision of Information					
			ation managements as are	ata Calaad	do AO	Yes	X No
11		the insurance company fail to provide any informa		ete Schedi	ле А ?	162	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
12	! If th	ne 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

For calendar plan year 20	17 or fiscal plai	n year beginning 01/01/2017		and en	aing 12/31/2017	7	
A Name of plan NELSON & SONS HEAL	TH INCLIDANC	E DI AN			e-digit		501
NELSON & SONS TIEAL	ITTINSURANC	L FLAN		plan	number (PN)	<u> </u>	301
C Plan sponsor's name as shown on line 2a of Form 5500  NELSON & SONS CONSTRUCTION CO., INC				-	yer Identification N 1726988	Number (	(EIN)
NELSON & SONS CONS	TRUCTION CO	J., INC		91-	1720900		
		rning Insurance Contrac  Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca COLONIAL LIFE & ACCID		NCE COMPANY					
/L\	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f) From		<b>(g)</b> To
57-0144607	62049	E4267043	7	,	01/01/2017		12/31/2017
2 Insurance fee and come descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents, broker	rs, and o	ther persons in
(a) Total a	amount of com			<b>(b)</b> To	otal amount of fees	s paid	
		822					177
3 Persons receiving com	missions and fo	ees. (Complete as many entries	s as needed to report all	persons).			
		and address of the agent, broker	•	m commiss	ions or fees were	paid	
ROBERT WILLIAM PLATT	E		227TH AVE NE DINVILLE, WA 98077				
(b) Amount of sales ar	nd base	Fe	es and other commission				-
commissions pai		(c) Amount		(d) Purpos	9		(e) Organization code
	425	33	EES				3
	(a) Nome of	and address of the agent broker	or other person to when	m commics	ione or food word	naid	
SANDRA L AYERS	(a) Name a	and address of the agent, broker 19230	LAKE FRANCES ROAD		ions of fees were	paiu	
		MAPL	E VALLEY, WA 98038				
(b) Amount of sales ar	nd hase	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
	194	109 F	EES				3
For Paperwork Reductio	n Act Notice,	see the Instructions for Form	5500.			Sche	dule A (Form 5500) 2017 v. 170203

Schedule A (Form 5500)	2017	Page <b>2 –</b> 1	
(a) Nav			
LISA LOUISE ROBBERSON		r, or other person to whom commissions or fees were paid	
	#3 KIRKL	_AND, WA 98034	
		, 1111	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
144	10	FEES	3
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
KENT ANTHONY SHERMAN		LAKE FRANCES ROAD SE	
	WAPL	E VALLEY, WA 98038	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
59	25	FEES	3
( ) )			
(a) Nai	ne 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	(c) Amount	(d) Purpose	Organization code
commissions paid	(-)	(4) - 1, 1, 1, 1	code
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	Г		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(4) 1101	The state of the agong broker	,	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(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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P	art	III 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 individ	ing purposes if such cont	racts are exp	perience-rated as a uni	t. Where co	ontracts cover individual
8	Ber	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
			_	<u>_</u>		nlaumant	=
	e	X Temporary disability (accident and sickness)	f ∐ Long-term disabili		Supplemental unem	pioyment	h Prescription drug
	I	Stop loss (large deductible)	j  HMO contract	K	PPO contract		I Indemnity contract
	m	Other (specify) ►AD&D, CRITICAL ILLNESS,	ACCIDENT (SUPPLEME	ENTAL)			
9	Exp	erience-rated contracts:			1		
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid					
		(3) Increase (decrease) in unearned premium res					
		(4) Earned ((1) + (2) - (3))			I	. 9a(4)	
	b	Benefit charges (1) Claims paid		a. (a)			_
		(2) Increase (decrease) in claim reserves				21.42	
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)	
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (c		0-(4)(A)	1		
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		0 (4)(0)			_
		(C) Other specific acquisition costs		0 (4)(D)			_
		(D) Other expenses(E) Taxes		0 (4)(5)			
		(F) Charges for risks or other contingencies.					_
		(G) Other retention charges					_
		(H) Total retention			1	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(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n					
10	_	onexperience-rated contracts:			<i>,</i> ,	.,	
	а	Total premiums or subscription charges paid to c	arrier			. 10a	8489
	b	If the carrier, service, or other organization incur	ed any specific costs in o	onnection wi	ith the acquisition or		
		retention of the contract or policy, other than repo	, ,			. 10b	
	Spe	cify nature of costs.					
Р	art	IV Provision of Information					
11	Di	d the insurance company fail to provide any inform	nation necessary to comp	lete Schedule	e A?	Yes	X No
12		he answer to line 11 is "Yes," specify the informat					
	•••	and the state of t					

### 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

					Inspection
Part i		entification Information			
For cale	endar plan year 2017 or fisc	al plan year beginning 01/01/2	017	and ending 12/3	1/2017
<b>A</b> This	return/report is for:	a multiemployer plan		oloyer plan (Filers checking themployer information in accord	nis box must attach a list of dance with the form instructions.)
		X a single-employer plan	a DFE (specif	y)	·
<b>B</b> This	return/report is:	the first return/report	the final return	n/report	
		an amended return/report	a short plan ye	ear return/report (less than 12	? months)
C If the	e plan is a collectively-barga	ained plan, check here			,,
D Chec	ck box if filing under:	Form 5558	automatic exte	nsion	the DFVC program
		special extension (enter description	1)		
Part I	Basic Plan Inform	nation—enter all requested informat	ion		
	ne of plan	th Insurance Plan			<b>1b</b> Three-digit plan number (PN) ▶ 500
	Ison & sons hear	ch insurance Fian			1c Effective date of plan 01/01/2008
Mai	ling address (include room,	er, if for a single-employer plan) apt., suite no. and street, or P.O. Box country, and ZIP or foreign postal cod	) e (if foreign, see instr	ructions)	2b Employer Identification Number (EIN) 91-1726988
Ne]	lson & Sons Const	truction Co., Inc			2c Plan Sponsor's telephone number 360-668-3800
	). Box 228		0 87th Avenue	2d Business code (see instructions) 237990	
WOC	darmviile	WA 98072 Wood	inville	WA 98072	
Caution	: A penalty for the late or	incomplete filing of this return/repo	ort will be assessed	unless reasonable cause is	established.
Under p stateme	enalties of perjury and othe nts and attachments, as we	r penalties set forth in the instructions, ell as the electronic version of this retur	I declare that I have n/report, and to the b	examined this return/report, i est of my knowledge and beli	ncluding accompanying schedules, ief, it is true, correct, and complete.
SIGN HERE	Show H	Inde	7/19/20	Sharon Handran	
112112	Signature of plan admir	nistrator	Date /	Enter name of individual si	gning as plan administrator
SIGN HERE					
	Signature of employer/	olan sponsor	Date	Enter name of individual si	gning as employer or plan sponsor
SIGN					-

Date

Signature of DFE

Enter name of individual signing as DFE

Form	5500	(2017)
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Page 2

3a	Plan administrator's name and address 🗵 Same as Plan Sponsor		3b Administrator's EIN		
			Administrator's telephone number		
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:		D EIN		
a C	-p		<b>I</b> PN		
5	Total number of participants at the beginning of the plan year		5 150		
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans compl 6a(2), 6b, 6c, and 6d).				
a(	a(1) Total number of active participants at the beginning of the plan year		a(1) 155		
a(	(2) Total number of active participants at the end of the plan year	6а	158		
b	<b>b</b> Retired or separated participants receiving benefits		6b 0		
С	Other retired or separated participants entitled to future benefits	6	6c 0		
d	Subtotal. Add lines 6a(2), 6b, and 6c	6	6d 158		
е	Deceased participants whose beneficiaries are receiving or are entitled to receive 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 (only defined contribut complete this item)	on plans	6g		
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested		Sh		
7			7		
8a b	b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  4A 4B 4D 4F 4L 4Q				
ча	🖫	9b Plan benefit arrangement (check all that apply) (1)			
		Code section 412(e)(3) insu	urance contracts		
		rust			
		Seneral assets of the spons			
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where in	dicated, enter the number a	attached. (See instructions)		
а	Pension Schedules b General Sched	lules			
	(1) R (Retirement Plan Information) (1)	H (Financial Information	on)		
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	I (Financial Information	on – Small Plan)		
	Purchase Plan Actuarial Information) - signed by the plan  (3)	$\frac{4}{2}$ <b>A</b> (Insurance Informat	tion)		
	actuary (4)	C (Service Provider In	nformation)		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial (5)	<b>D</b> (DFE/Participating F	Plan Information)		
	Information) - signed by the plan actuary (6)	G (Financial Transacti	ion Schedules)		