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 A	nnual Report Ider	ntification Information				
For calendar pl	an year 2017 or fiscal p	plan year beginning 01/01/2017	and ending 12/31/20)17		
A This return/	report is for:	a multiemployer plan	a multiple-employer plan (Filers checking the			
		7	participating employer information in accor	dance wit	th the form instruction	ns.)
B This return/report is:		a single-employer plan	a DFE (specify)			
		the first return/report	the final return/report			
		an amended return/report	a short plan year return/report (less than 12	2 months))	
C If the plan is	a collectively-bargaine	ed plan, check here			• [
D Check box i	f filing under:	Form 5558	automatic extension	the	e DFVC program	
		special extension (enter descript	ion)			
Part II Ba	asic Plan Informa	ntion—enter all requested inform	ation			
1a Name of plan FRONTIER BEHAVIORAL HEATLH HEALTHCARE BENEFIT PLAN				1b	Three-digit plan number (PN) ▶	501
				1c	1c Effective date of plan 01/01/2012	
Mailing add	2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)				2b Employer Identification Number (EIN) 91-0853801	
FRONTIER BEI	HAVIORAL HEALTH			2c Plan Sponsor's telephone number 509-838-4651		phone
107 S DIVISION ST SPOKANE, WA 99202-1510 107 S DIVISION ST SPOKANE, WA 99202-1510			2d	Business code (see instructions) 621420)	
Caution: A per	nalty for the late or in	complete filing of this return/re	port will be assessed unless reasonable cause is	s establis	shed.	
Under penaltie	s of periury and other r	penalties set forth in the instruction	as I declare that I have examined this return/report	including	accompanying sche	dules

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	Filed with authorized/valid electronic signature. Signature of plan administrator	07/31/2018 Date	CRAIG DUNLAP Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/31/2018	CRAIG DUNLAP
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
IILIKE	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

			_		
2-	Form 5500 (2017)		Page 2	26	
Ja	Plan administrator's name and address X Same as Plan Sponsor			3b Administrato	r's EIN
				3c Administrato number	r's telephone
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 the plan name and the plan na			4b EIN	
a c	Sponsor's name Plan Name			4d PN	
5	Total number of participants at the beginning of the plan year			5	470
6	Number of participants as of the end of the plan year unless otherwise states $6a(2)$, $6b$, $6c$, and $6d$).	d (welfare p	lans complete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year			<mark>6a(1)</mark>	470
a(2) Total number of active participants at the end of the plan year			6a(2)	470
b	Retired or separated participants receiving benefits			6b	
С	Other retired or separated participants entitled to future benefits			6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c			6d	470
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benef	its	6e	
f	Total. Add lines 6d and 6e.			6f	470
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 witless than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only	multiemplo	yer plans complete this item)	7	
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from th	e List of Plan Characteristics Coo	des in the instruction	าร:
b	If the plan provides welfare benefits, enter the applicable welfare feature coc 4A 4B 4D 4E 4F 4H	des from the	List of Plan Characteristics Code	es in the instructions	S :
9a	Plan funding arrangement (check all that apply)	9b Plan	benefit arrangement (check all the	nat apply)	
	(1) X Insurance	(1)	X Insurance		
	Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3)) insurance contract	is
	(3) Trust (4) X General assets of the sponsor	(3)	Trust X General assets of the s	choncor	
10	(4) X General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are a	(4) attached, an		•	instructions)
		_		(500	- · · · · · · · · · · · · · · · · · · ·
d	Pension Schedules (1) R (Retirement Plan Information)	D Ger (1)	neral Schedules H (Financial Infor	mation)	
		(2)	H	mation – Small Plar	n)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3)	X 4 A (Insurance Info		·,

(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.)						
11b 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)

Page 3

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

•			ERISA section 103(a)(2)		llion	This For	m is Open to Public Inspection
For calendar plan year 20	17 or fiscal pla	an year beginning 01/01/2017		and en	nding 12/31/2	2017	
A Name of plan FRONTIER BEHAVIORAL HEATLH HEALTHCARE BENEFIT Plant 1997					ee-digit n number (PN)	•	501
C Plan sponsor's name a FRONTIER BEHAVIORAL	L HEALTH			91-	oyer Identification		
on a separa		rning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca SUN LIFE ASSURANCE C		CANADA					
/L.\	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) Fr	om	(g) To
38-1082080	80802	226199	470		01/01/2017		12/31/2017
2 Insurance fee and communication descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, bro	okers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
13357 15204						15204	
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	r, or other person to whor	n commiss	sions or fees we	ere paid	
HUB INTERNATIONAL NO	ORTHWEST L		OX 3018 HELL, WA 98041				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pai	id	(c) Amount	((d) Purpos	se		(e) Organization code
	13357	15204					3
	(a) Name	and address of the agent, broke	er, or other person to whor	n commiss	sions or fees we	ere paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pai	id	(c) Amount		(d) Purpos	se		(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [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
(a) 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
(a) 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) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) 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)			
		•				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

ı	Page	4

F	art	III	Welfare Benefit Contract Information for than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such conti	racts are exp	erience-rated as a unit	t. Where con	tracts cover indivi	
8	Ben	efit a	nd contract type (check all applicable boxes)						
	а	Пне	ealth (other than dental or vision)	b Dental	сГ	Vision	C	Life insurance	e
	e [=	emporary disability (accident and sickness)	f Long-term disabilit	<u> </u>	<u></u>		Prescription	
	. [_		<u> </u>	_	=	pioyinient i	- H	•
	1 2	_	op loss (large deductible)	j HMO contract	K_	PPO contract		I Indemnity co	ntract
	m	Ot	her (specify)						
9			ce-rated contracts:	ļ					
	a I		iums: (1) Amount received		9a(1)		710819		
			ncrease (decrease) in amount due but unpaid						
			ncrease (decrease) in unearned premium res	•			0.74		740046
	L	. ,	Earned ((1) + (2) - (3))				9a(4)		710819
	b		efit charges (1) Claims paid						
			ncrease (decrease) in claim reserves				01- (0)		
			ncurred claims (add (1) and (2))						
	_	` '	Claims charged(1) Peterties charges (•••••		9b(4)		
	С		nainder of premium: (1) Retention charges (o	,	00/1\/A\				
			(A) Commissions		9c(1)(A) 9c(1)(B)				
			(B) Administrative service or other fees (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)		
		(2) [Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)			
	d		us of policyholder reserves at end of year: (1	<u>—</u>					
			Claim reserves				9d(2)		
		` '	Other reserves				9d(3)		
	е	` '	dends or retroactive rate refunds due. (Do no						
10			erience-rated contracts:		, ,	,			
	а	Tota	al premiums or subscription charges paid to c	arrier			10a		
	b	If the	e carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	th the acquisition or			
	_	rete	ntion of the contract or policy, other than repo				. 10b		
			ature of costs.						
P	art	V	Provision of Information					7	
11	Dic	the	insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes X	No	
12	2 If t	he ar	nswer 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

		pursuant to E	RISA 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 FRONTIER BEHAVIORAL	L HEATLH HEA	ALTHCARE BENEFIT PLAN			e-digit number (PN	N) •	501
C Plan sponsor's name a FRONTIER BEHAVIORAL		e 2a of Form 5500		-	oyer Identific 0853801	ation Number (EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance car RELIANCE STANDARD	rrier						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			Policy or co	ontract year
(5) EIN	code	identification number	policy or contrac		(f)	From	(g) To
36-0883760	68381	124602	503	3	01/01/2017	7	12/31/2017
2 Insurance fee and communication descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comn			(b) To	otal amount	of fees paid	
		9233					
3 Persons receiving com		ees. (Complete as many entries					
HUB INTERNATIONAL NO			•	m commiss	ions or fees	were paid	
(b) Amount of sales ar			s and other commission				
commissions pai	9233	(c) Amount		(d) Purpose			(e) Organization code
	9233						7
	(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
For Donomicals Doductio	n Act Notice o	see the Instructions for Form F	E00			Cabaa	Iula A (Farm FE00) 2017

Schedule A (Form 5500)	2017	Page 2 – [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
(a) 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
(a) 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) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) 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)				
	_			, _		
	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)			
		•				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

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Р	art	III Welfare Benefit Contract Informa	ation				
		If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual.	ing purposes if such conti	racts are exp	erience-rated as a uni	it. Where co	ontracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)			·		
	а	Health (other than dental or vision)	b Dental	сГ	Vision		d Life insurance
	L			<u> </u>	<u>-</u>		
	e		f Long-term disabilit		<u> </u>	ipioyment	h Prescription drug
	1	Stop loss (large deductible)	j HMO contract	k L	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Ехре	erience-rated contracts:	ı				
	a I	Premiums: (1) Amount received		9a(1)		198044	4
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				. 9a(4)	198044
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				. 9b(3)	
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (or	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses					
		(E) Taxes					
		(F) Charges for risks or other contingencies					
		(G) Other retention charges		9c(1)(G)		T	
		(H) Total retention	_	_		. 9c(1)(H)
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)) Amount held to provide	benefits after	r retirement	. 9d(1)	
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves				. 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)).)	. 9e	
10	No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			. 10a	
	b	If the carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	th the acquisition or		
	_	retention of the contract or policy, other than repo	orted in Part I, line 2 above	e, report amo	ount	10b	
	Spe	ecify nature of costs.					
Р	art	IV Provision of Information					
11		d the insurance company fail to provide any inform	ation necessary to compl	ata Schadula	Λ2 Π	Yes	X No
				ete ocheaule	5 M!	100	N 110
12	If t	the answer to line 11 is "Yes," specify the informati	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant to E	RISA 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 FRONTIER BEHAVIORA	L HEATLH HEA	ALTHCARE BENEFIT PLAN			e-digit number (PN	N) •	501
C Plan sponsor's name a FRONTIER BEHAVIORAL		e 2a of Form 5500		-	oyer Identific 0853801	ation Number (EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or co	•
(5) 2	code	identification number	policy or contrac		(f)	From	(g) To
91-0621480	47341	00712	514	ļ.	01/01/2017	7	12/31/2017
2 Insurance fee and communication descending order of the		tion. 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) To	otal amount	of fees paid	
		3990					
3 Persons receiving com		ees. (Complete as many entries					
HUB INTERNATIONAL NO			•	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai	id	(c) Amount		(d) Purpose			(e) Organization code
	3990						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 s	saa tha Instructions for Form F	EOO			Cabaa	Iula A (Farm FEOO) 2017

Schedule A (Form 5500)	2017	Page 2 – [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
(a) 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
(a) 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) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) 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)				
	_			, _		
	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)			
		•				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

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P	art	Ш	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 individ	dual contracts with each ca	arrier may be	treated as a unit for purpos	ses of this r	eport.
8	Ber	nefit a	nd contract type (check all applicable boxes)					'
-	а	_	ealth (other than dental or vision)	b X Dental	с	Vision	d∫	Life insurance
	l			. H	<u> </u>	<u>4</u> -	L	=
	e	片	mporary disability (accident and sickness)	f Long-term disabili	·	Supplemental unemployr	_	·
	I	Sto	op loss (large deductible)	j HMO contract	K_	PPO contract	ıſ	Indemnity contract
	m	Ot	her (specify)					
9	Exp	eriend	ce-rated contracts:					
	а		iums: (1) Amount received		` '	;	399682	
			ncrease (decrease) in amount due but unpai					
			ncrease (decrease) in unearned premium res				- (1)	00000
	L	. ,	arned ((1) + (2) - (3))				9a(4)	399682
	b		efit charges (1) Claims paid			4	282830	
			ncrease (decrease) in claim reserves			T ,	-3000	279830
			ncurred claims (add (1) and (2))				9b(3) 9b(4)	2/9030
	С	` '	claims charged				,D(4)	
	C		(A) Commissions	,	9c(1)(A)		3990	
			(B) Administrative service or other fees				55162	
			(C) Other specific acquisition costs		0 (4)(0)		00102	
			(D) Other expenses					
			(E) Taxes		2 (4)(5)			
			(F) Charges for risks or other contingencies.					
			(G) Other retention charges		0.74\70\			
		((H) Total retention			90	:(1)(H)	59152
		(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			9	9d(2)	10000
		(3) (Other reserves				9d(3)	
			dends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2)	.)	9e	
10	No	onexp	erience-rated contracts:					
	а	Tota	I premiums or subscription charges paid to o	carrier			10a	
	b		e carrier, service, or other organization incur					
	Sno		ntion of the contract or policy, other than rep	orted in Part I, line 2 abov	e, report amo	ount	10b	
	Spe	ecity i	ature of costs.					
_	ort.	IV/	Provision of Information					
	art		Provision of Information					
11			insurance company fail to provide any inforn		ete Schedule	A? Yes	X	No
12	12 If the answer to line 11 is "Yes," specify the information not provided.							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

			RISA section 103(a)(2).	Inis Fo	Inspection
For calendar plan year 20	17 or fiscal plar	n year beginning 01/01/2017	and e	ending 12/31/2017	•
A Name of plan FRONTIER BEHAVIORA	L HEATLH HE	ALTHCARE BENEFIT PLAN		ee-digit n number (PN)	501
C Plan sponsor's name a FRONTIER BEHAVIORAL		e 2a of Form 5500		loyer Identification Numbe I-0853801	r (EIN)
		rning Insurance Contract Individual contracts grouped as			
1 Coverage Information:					
(a) Name of insurance ca SUN LIFE ASSURANCE C		CANADA			
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To
38-0182080	80802	232701	510	01/01/2017	12/31/2017
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tota	I commissions paid. List in line 3	3 the agents, brokers, and	other persons in
(a) Total a	amount of com		(b) 1	Total amount of fees paid	
		4762			3057
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all persons).		
		and address of the agent, broker,		sions or fees were paid	
HUB INTERNATIONAL NO	ORTHWEST LL		(3018 LL, WA 98041		
(b) Amount of sales ar	nd base	Fee	s and other commissions paid		
commissions pa		(c) Amount	(d) Purpo	se	(e) Organization code
	4762	3057			3
	(a) Name a	and address of the agent, broker,	or other person to whom commis	sions or fees were paid	
(b) Amount of sales ar	nd base	Fee	s and other commissions paid		
commissions pa		(c) Amount	(d) Purpo	(e) Organization code	
For Panerwork Reduction	n Act Notice	see the Instructions for Form 5	500	Sch	edule A (Form 5500) 2017

Schedule A (Form 5500)	2017	Page 2 – [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
(a) 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
(a) 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) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) 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)			
		•				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

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Р	art						
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ting purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabili	<u> </u>	Supplemental unem		h Prescription drug
	: [·	3	pioyment	=
	י ן	Stop loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity contract
	m	Other (specify)					
9	•	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				0=/4)	
	h	(4) Earned ((1) + (2) - (3))				. 9a(4)	
	b	Benefit charges (1) Claims paid		(-)			_
		(2) Increase (decrease) in claim reserves				0h/3)	
		(4) Claims charged				9b(3) 9b(4)	
	С	Remainder of premium: (1) Retention charges (o		•••••		. 30(4)	
	Ü	(A) Commissions		9c(1)(A)			-
		(B) Administrative service or other fees		- (1)(-)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		0 (4)(D)			
		(E) Taxes		0 (4)(=)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves				. 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)	. 9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to o	carrier			. 10a	181265
	b	If the carrier, service, or other organization incurr					
	Sn.	retention of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	ount	10b	
	Spe	cify nature of costs.					
Р	art	IV Provision of Information					
11		d the insurance company fail to provide any inform	nation necessary to comp	ete Schedula	. д?	Yes	X No
		· · · · · · · · · · · · · · · · · · ·		ore oculeante	л:		<u> </u>
14	. IT t	he answer to line 11 is "Yes," specify the informati	ion not provided. 🔻				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Service Provider 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

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	B Three-digit		
FRONTIER BEHAVIORAL HEATLH HEALTHCARE BENEFIT PLAN	plan number (PN)	501	
0.5	5		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (I	EIN)	
FRONTIER BEHAVIORAL HEALTH	91-0853801		
Part I Service Provider Information (see instructions)			
Variable to a second a second and a second and a second and a second and a second at the second at the second and a second at the second at th	in an arrived for some more who are sixed	dina athu an in dina athu &F 000	
You must complete this Part, in accordance with the instructions, to report the informat or more in total compensation (i.e., money or anything else of monetary value) in conne			
plan during the plan year. If a person received only eligible indirect compensation for			
answer line 1 but are not required to include that person when completing the remainded	er of this Part.		
4 Information on Boscomo Boscivina Only Fligible Indigest Company			
1 Information on Persons Receiving Only Eligible Indirect Comper		iblo	
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainde indirect compensation for which the plan received the required disclosures (see instruc	, , ,		
indirect compensation for which the plan received the required disclosures (see instruc-	uons for definitions and conditions)	Yes XNo	
b If you answered line 1a "Yes," enter the name and EIN or address of each person pro received only eligible indirect compensation. Complete as many entries as needed (see		e providers who	
(b) Enter name and EIN or address of person who provided you	ou disclosures on eligible indirect compensat	ion	
(b) Enter name and EIN or address of person who provided yo	ou disclosures on eligible indirect compensat	ion	
(b) Enter name and EIN or address of person who provided yo	ou disclosures on eligible indirect compensat	ion	
(7)	,		
(b) Enter name and EIN or address of person who provided yo	ou disclosures on eligible indirect compensat	ion	
- The hame and Environ address of person who provided ye	sa alesiseares en englere maneet compensat		

Schedule C (Form 5500) 2017	Page 2- 1
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person where	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the control of th	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).						
		((a) Enter name and EIN or	address (see instructions)		
FIRST CHO	DICE HEALTH NETW	ORK	SUITE	IVERSITY STREET 1400 LE, WA 98101		
91-127276	6					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
73	PPO NETWORK	43670	Yes No X	Yes No		Yes No X
		(a) Enter name and EIN or	address (see instructions)		
AMERIBEN IEC GROUP TPA 3449 E COPPER POINT DRIVE MERIDIAN, ID 83642 82-0308198						
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	CLAIM PROCESSING / CMU	171807	Yes No 🗵	Yes No		Yes No X
		(a) Enter name and EIN or	address (see instructions)		
HUB INTERNATIONAL NORTHWEST, LLC 12100 NE 195TH STREET SUITE 200 BOTHELL, WA 98011						
91-2036015						
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
6	CONSULTANT	59365	Yes No	Yes No		Yes No

Page **3 -** 1

Schedule C (Form 5500) 2017

Page	3 -	2
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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).							
	, , ,	,		address (see instructions)		,	
	(a) the name and the decision (see mondere)						
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?	
			Yes No	Yes No		Yes No	
		((a) Enter name and EIN or	address (see instructions)			
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?	
			Yes No	Yes No		Yes No	
		(a) Enter name and EIN or	address (see instructions)			
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?	
			Yes No	Yes No		Yes No	

Page	4	-	I
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Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compen or provides contract administrator, consulting, custodial, investment advisory, investment ma questions for (a) each source from whom the service provider received \$1,000 or more in ind provider gave you a formula used to determine the indirect compensation instead of an amount many entries as needed to report the required information for each source.	nagement, broker, or recordkeepinç lirect compensation and (b) each so	g services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

Page **5 -** 1

Port II Comice Dreviders Who Feil or Defuse to Drevide Information					
this Schedule.	Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete his Schedule.				
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
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(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide		

Schedule C (Form 5500) 2017

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)				
	(complete as many entries as needed)	<u> </u>		
а	Name:	b EIN:		
С	Position:			
d	Address:	e Telephone:		
u	Address.	С теюрионе.		
Ex	planation:			
а	Name:	b EIN:		
С	Position:			
d	Address:	e Telephone:		
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⊏X	planation:			
а	Name:	b EIN:		
С	Position:			
d	Address:	e Telephone:		
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C	Position:			
d	Address:	e Telephone:		
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а	Name:	b EIN:		
C	Position:	₩ LIIV.		
d		e Telephone:		
u	Address:	с тејернопе:		
Explanation:				