Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2017

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

A This return/report is for:
- [ ] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
- [X] a single-employer plan
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [ ] a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
WINTON-IRELAND INSURANCE AGENCY INC. CAFETERIA PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 10/01/1994

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)

WINTON-IRELAND INSURANCE AGENCY, INC.
WINTON IRELAND, STROM & GREEN INSURANCE AGENCY
LYNN M. BULL, PLAN ADMINISTRATOR
627 E CANAL DR
TURLOCK, CA 95380-4022

PO BOX 3277
TURLOCK, CA 95381-3277

2b Employer Identification Number (EIN) 94-2667917

2c Plan Sponsor's telephone number 209-667-0995

2d Business code (see instructions) 524210

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

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/11/2018	LYNN BULL
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/11/2018	LYNN BULL
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since 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:
a Sponsor's name
c Plan Name

4b EIN

4d PN

5 Total number of participants at the beginning of the plan year	**5**	154
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1) Total number of active participants at the beginning of the plan year	**6a(1)**	154
a(2) Total number of active participants at the end of the plan year	**6a(2)**	139
b Retired or separated participants receiving benefits	**6b**	3
c Other retired or separated participants entitled to future benefits	**6c**	
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	142
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f Total. Add lines **6d** and **6e**.	**6f**	142
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

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 4E 4H

9a Plan funding arrangement (check all that apply)

(1)	[X]	Insurance
(2)	[ ]	Code section 412(e)(3) insurance contracts
(3)	[ ]	Trust
(4)	[ ]	General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1)	[X]	Insurance
(2)	[ ]	Code section 412(e)(3) insurance contracts
(3)	[ ]	Trust
(4)	[ ]	General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

(1)	[ ]	**R** (Retirement Plan Information)
(2)	[ ]	**MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
(3)	[ ]	**SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

(1)	[ ]		**H** (Financial Information)
(2)	[ ]		**I** (Financial Information – Small Plan)
(3)	[X]	5	**A** (Insurance Information)
(4)	[ ]		**C** (Service Provider Information)
(5)	[ ]		**D** (DFE/Participating Plan Information)
(6)	[ ]		**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.) ..... ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter 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 Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

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
WINTON-IRELAND INSURANCE AGENCY INC. CAFETERIA PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
WINTON-IRELAND INSURANCE AGENCY, INC.

D Employer Identification Number (EIN)
94-2667917

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
UNITEDHEALTHCARE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-2739571	79413	909913	144	01/01/2017	12/31/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

WINTON-IRELAND INSURANCE AGENCY, IN
PO BOX 3277
TURLOCK, CA 95381-3277

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	0		3

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

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	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a 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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	**6d**	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation 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)**			
	(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)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	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**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [X] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
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)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(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 retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	838733
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

A Name of plan
WINTON-IRELAND INSURANCE AGENCY INC. CAFETERIA PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
WINTON-IRELAND INSURANCE AGENCY, INC.

D Employer Identification Number (EIN)
94-2667917

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
KAISER FOUNDATION HEALTH PLAN INC.

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
94-1340523	00000	600027	58	01/01/2017	12/31/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a 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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	**6d**	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation 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)**			
	(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)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	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**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** ☐ Health (other than dental or vision)
- **b** ☐ Dental
- **c** ☐ Vision
- **d** ☐ Life insurance
- **e** ☐ Temporary disability (accident and sickness)
- **f** ☐ Long-term disability
- **g** ☐ Supplemental unemployment
- **h** ☐ Prescription drug
- **i** ☐ Stop loss (large deductible)
- **j** ☐ HMO contract
- **k** ☐ PPO contract
- **l** ☐ Indemnity contract
- **m** ☐ Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
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)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(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 retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	276102
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

A Name of plan
WINTON-IRELAND INSURANCE AGENCY INC. CAFETERIA PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
WINTON-IRELAND INSURANCE AGENCY, INC.

D Employer Identification Number (EIN)
94-2667917

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
VISION SERVICE PLAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-1632821	00000	12254246	76	01/01/2017	12/31/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

WINTON-IRELAND INSURANCE AGENCY, IN
PO BOX 3277
TURLOCK, CA 95381-3277

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
0	0		3

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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	(c) Amount	**(d)** Purpose	

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	(c) Amount	**(d)** Purpose	

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a 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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	**6d**	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation 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)**			
	(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)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	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**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** ☐ Health (other than dental or vision)
- **b** ☐ Dental
- **c** ☐ Vision
- **d** ☐ Life insurance
- **e** ☐ Temporary disability (accident and sickness)
- **f** ☐ Long-term disability
- **g** ☐ Supplemental unemployment
- **h** ☐ Prescription drug
- **i** ☐ Stop loss (large deductible)
- **j** ☐ HMO contract
- **k** ☐ PPO contract
- **l** ☐ Indemnity contract
- **m** ☐ Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
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)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(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 retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	14935
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

A Name of plan
WINTON-IRELAND INSURANCE AGENCY INC. CAFETERIA PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
WINTON-IRELAND INSURANCE AGENCY, INC.

D Employer Identification Number (EIN)
94-2667917

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
SUN LIFE ASSURANCE COMPANY OF CANADA

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
38-1082080	80202	247138	103	01/01/2017	12/31/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

WINTON-IRELAND INSURANCE AGENCY, IN
PO BOX 3277
TURLOCK, CA 95381-3277

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
70			3

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a 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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	**6d**	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation 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)**			
	(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)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	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**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** ☐ Health (other than dental or vision)
- **b** ☐ Dental
- **c** ☐ Vision
- **d** ☐ Life insurance
- **e** ☐ Temporary disability (accident and sickness)
- **f** ☐ Long-term disability
- **g** ☐ Supplemental unemployment
- **h** ☐ Prescription drug
- **i** ☐ Stop loss (large deductible)
- **j** ☐ HMO contract
- **k** ☐ PPO contract
- **l** ☐ Indemnity contract
- **m** ☐ Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
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)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(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 retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	38607
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

A Name of plan
WINTON-IRELAND INSURANCE AGENCY INC. CAFETERIA PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
WINTON-IRELAND INSURANCE AGENCY, INC.

D Employer Identification Number (EIN)
94-2667917

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
HARTFORD LIFE AND ACCIDENT

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
06-0838648	70815	868076G	109	01/01/2017	12/31/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

WINTON-IRELAND INSURANCE AGENCY, IN
PO BOX 3277
TURLOCK, CA 95381-3277

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
0			3

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

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	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a 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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	**6d**	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation 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)**			
	(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)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	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**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** ☐ Health (other than dental or vision)
- **b** ☐ Dental
- **c** ☐ Vision
- **d** ☐ Life insurance
- **e** ☐ Temporary disability (accident and sickness)
- **f** ☐ Long-term disability
- **g** ☐ Supplemental unemployment
- **h** ☐ Prescription drug
- **i** ☐ Stop loss (large deductible)
- **j** ☐ HMO contract
- **k** ☐ PPO contract
- **l** ☐ Indemnity contract
- **m** ☐ Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
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)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(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 retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	4302
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

UnitedHealthcare®
A UnitedHealth Group Company

April 18, 2018

Lynn Bull
Winton-Ireland Insurance
687 E Canal Drive
Turlock CA 95380

RECEIVED
04 30 18
Winton-Ireland
Strom & Green

Dear Valued Customer:

Employee Retirement Income Security Act of 1974 (ERISA)

We have enclosed information that you may need for completing the 5500 Form Schedule A. This information reflects compensation paid to your agent or consultant for the plan year that recently ended for the coverage's you have with us.

We are reporting any base commissions, bonuses and other types of compensation paid in relation to the plan during the plan year. Please note that only base commissions are included in the specific calculation of your premium or administrative service fee. Bonus and other non-base commission payments are not directly included in the determination of your premium or administrative service fee. Bonus payments may be based on the recipient's combined block of business and are allocated to cases according to their contribution to the amount earned.

IMPORTANT NOTE: The enclosed information may be divided into two reports. Some customers may receive a 5500 Addendum Report in addition to the standard 5500 Schedule A report form. The 5500 Addendum Report itemizes bonus compensation and payments that were processed manually separately. **If you have received the 5500 Addendum Report as well as the standard 5500 Schedule A report form, you will need to add the amounts in the Total line of the 5500 Addendum Report to the amount found in the standard 5500 Schedule A report form.**

Should you have any questions related to this information, please contact your agent, consultant, or the UnitedHealthcare Strategic Account Executive assigned to your case.

I hereby certify that to the best of my knowledge, information or belief at this time, and based upon information provided by duly authorized personnel, the foregoing statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate.

Thank you.

Sincerely,

D.J. Fitzgerald
Vice President Broker and Employer Operations

Schedule A (Form 5500) Parts I and III
Insurance Information Certified by Carrier
Department of Labor Pension and Welfare Benefits

Principal Address:
687 E Canal Drive
Turlock CA 95380

A Name of Plan:
Winton-Ireland Insurance

Part I Information Concerning Insurance Contract Coverage, Fee, and Commissions

1. Coverage

(a) Name of Insurance carrier: UnitedHealthcare Insurance Company

(b) EIN: 36-2739571 (c) NAIC code: 79413 (d) Contract or identification number: 909913

(e) Approximate number of persons covered at the end of policy or contract year: * 144

* If the policy holder determines that they have a more accurate count, they should use their figure.

Policy or Contract year (f) from: 1/1/2017 (g) to: 12/31/2017

2. Insurance fees and commissions paid to agents, brokers, and other persons

Totals Total amount of commissions Paid: N\A Total fees paid/amount: N\A

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid:

#N/A

(b) Amount of commissions paid: N\A
(c) Fees paid/Amount: N\A
(d) Fees paid/Purpose: N\A
e) Organizational Code: 3

Part III Welfare Benefit Contract Information

7. Benefit and contract type
(a) Health

9. Non experience-rated contracts:
(a) Total premiums or subscription charges paid to carrier: $838,732.54
Total Fees paid to Carrier N\A

(b) Additional costs incurred by carrier, service, or other
Organization not reported in Part 1, item 2 above: $0.00

Specify Nature of cost:

KAISER PERMANENTE®

Attention: 5500 Central Team
3840 Murphy Canyon Road
San Diego, CA 92123

RECEIVED
02/27/18
Winton Ireland
Sprom & Green

AB 01 007031 02587 H 28 C

WINTON-IRELAND INSURANCE AGENCY, INC.
LYNN BULL
PO BOX 3277
TURLOCK, CA 95381-3277

Reporting Period: 01/2017 - 12/2017

02/19/2018

007031 1/2

Dear WINTON-IRELAND INSURANCE AGENCY, INC.:

Enclosed is information from Kaiser Permanente that may assist you in the completion of Schedule A to the Form 5500. The enclosed report provides you with the following information:

- Kaiser Permanente's Employer Identification Number (EIN) and National Association of Insurance Commissioners (NAIC) code.
- The name and address of your broker, or other agent working on your behalf, who received compensation from Kaiser Permanente during your plan's contract year.
- The amount of sales and base commissions paid to your broker, or other agent working on your behalf, during your plan's contract year.
- The amount of any fees paid to your broker, or other agent working on your behalf, during your plan's contract year. (Please note that bonus payments and non-monetary compensation are defined as fees on the actual Schedule A to the Form 5500.)
- The approximate number of covered persons as of the last day of your contract year. (The approximate number of covered persons includes the number of health plan subscribers in addition to their spouses and dependents, if any.)
- The total amount of premiums received by Kaiser Permanente during your plan's contract year.

Please be aware that the amount of premium dollars provided on the enclosed report is based on the date Kaiser Permanente processed and deposited your premium payment. The enclosed premium information is not based on coverage or billing periods.

Kaiser Permanente is providing the enclosed information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist in the completion of Schedule A to the Form 5500. If you feel you have received this information in error and do not file the Form 5500, please contact your Kaiser Permanente representative to request to have this report discontinued in future years. If you are unsure about your requirement to file the Form 5500 you should contact your broker, tax advisor, legal counsel or other qualified advisor for guidance. Kaiser Permanente is unable to help determine if you are required to file the Form 5500.

We at Kaiser Permanente value our business relationship with you and trust that you share our philosophy of maintaining the highest ethical standards of business practices. Our practices for broker compensation disclosure reporting reflect our shared commitment to full compliance with the law. Thank you for your continued support.

Sincerely,
Kaiser Permanente
(877) 639-0433

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KAISER PERMANENTE®

INSURANCE INFORMATION

Insurance companies are required to provide the following information pursuant to section 103 (a)(2) of the Employee Income Securities Act of 1974 (ERISA) to assist you in completing the Schedule A of your Form 5500.

Part I: Information Concerning Insurance Coverage, Fees, and Commissions

Name of Insurance Carrier: Kaiser Foundation Health Plan Inc
Plan Sponsor's Name: WINTON-IRELAND INSURANCE AGENCY, INC.

007031 2/2

Information Concerning Insurance Contract Coverage

Kaiser Foundation Health Plan Region: CA
Insurance Carrier: Kaiser Foundation Health Plan Inc
Insurance Carrier Employer Identification Number: 94-1340523
Insurance Carrier NAIC Code: 00000
Plan Sponsor Contract or Identification Number: 600027
Approximate number of persons covered at end of policy contract year: 58
Contract Year from 01/2017 - 12/2017

Information Concerning Insurance Contract Fees and Commissions

Total Amount of Commissions Paid: $0.00
Total Amount of Fees Paid: $0.00

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

None

Amount of sales and base commissions paid to: None: $0.00
Fees and other compensation paid to: None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation:$0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to: None: $0.00
Fees and other compensation paid to: None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation:$0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to: None: $0.00
Fees and other compensation paid to: None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation:$0.00
Type/Purpose of Non-Monetary Compensation: None

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

None

Amount of sales and base commissions paid to: None: $0.00
Fees and other compensation paid to: None: $0.00
Bonus Amount: $0.00
Bonus Purpose: None
Value of Non-Monetary Compensation:$0.00
Type/Purpose of Non-Monetary Compensation: None

Part II: Investment and Annuity Contract Information

Kaiser Foundation Health Plan Inc is not offering you an investment or annuity contract.

Part III: Welfare Benefit Contract Information

Premium received by Kaiser Foundation Health Plan Inc during your plan's contract year: $276,102.46

Part IV: Provision of Information

Kaiser Foundation Health Plan, Inc. hereby certifies that the foregoing statement furnished pursuant to 29 US Code of Federal Regulations 2520.103(c) is complete and accurate.

Barbara Ishikawa

Barbara Ishikawa
Vice President, Commercial Membership Administration
Kaiser Foundation Health Plan, Inc
02/19/2018

RECEIVED
020618
Winton-Ireland
Strom & Green

SCHEDULE A (Form 5500) Insurance Information

If Schedule A information is required to file a complete Form 5500 or Form 5500 C/R, information from this form must be transcribed onto IRS Schedule A (Form 5500) Insurance Information form (Cat. No. 13505I) as required by federal regulation.

WINTON-IRELAND INSURANCE AGENC
LYNN BULL
627 E CANAL DR
TURLOCK CA 95380-4022

Group No: **12254246**
Ins. Carrier: Vision Service Plan
Ins. Carrier NAIC Code No: **N/A**
Ins. Carrier FEIN: **941632821**
Benefit Type: Vision Care
Policy or Contract Year: **01/01/2017 - 12/31/2017**

Group Legal Name and Address:

WINTON-IRELAND INSURANCE AGENCY INC.
PO BOX 3277
TURLOCK CA 95381-3277

Approximate Number of Persons Covered at the End of Policy or Contract Year: **76**

Payments

Total Payments Made to Carrier: **$14,934.61**

Insurance Fees and Commissions Paid to Agents and Brokers:

Agent or Broker	Commissions/Fees Paid for Policy or Contract Year
WINTON IRELAND STROM & GREEN **PO BOX 3277** **TURLOCK CA 95381-3277**	**$0.00**

IF YOU HAVE QUESTIONS REGARDING THE TRANSPOSITION OF INFORMATION CONTAINED IN THIS REPORT, CONTACT YOUR INTERNAL COMPLIANCE OFFICE.

Vision Service Plan hereby certifies that this statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate as of 1/28/2018.

EXDM5500/**R00224/12254246/1/20180128**

CAT#01228 JOB#19493XA 12/14

Sun Life Financial®

Sun Life Assurance
Company of Canada

SC3238
One Sun Life Executive Park
Wellesley Hills, MA 02481-5699
email: ebg_commissions@sunlife.com

Tel: 1-800-440-1311

3743

WINTON-IRELAND INSURANCE AGENCY, INC
ATTN: BENEFIT ADMINISTRATOR
627 EAST CANAL DRIVE
TURLOCK, CA 95380

March 05, 2018

RECEIVED
031218
Winton-Ireland
Strom & Green

Re: Schedule A (Form 5500) Insurance Information
Group Policy Number: 247138

Dear Valued Customer:

We are sending you the enclosed information to assist you in completing Schedule A/C, of IRS/DOL/PBGC Form 5500. We are providing Schedule A/C information to you because we cannot be certain whether or not you require it. Sun Life Financial does not administer your plan and cannot provide tax and legal advice regarding your plan or policies. Please let us know in writing if you do not file a Schedule A/C of Form 5500 and you do not wish to receive this information in the future. We will not resume Schedule A/C reporting with respect to the above-referenced policy unless you otherwise notify us in writing.

The enclosed information includes all the premiums and/or fees we received, as well as all commissions paid to your broker. The commission information may include:

- Base commissions which are policy specific and are included in the policy rate(s).
- Override commissions (sometimes referred to as special payments, or program management fees) which are also policy specific but generally are not included in the policy rate(s).
- Bonus commission and producer conference fees which are not policy specific. They are paid based upon the anticipated annual premiums of all your broker's or administrator's policies with us. The amount of the bonus that is paid to your broker and attributable to your policy is determined by allocating the total bonus amount for the calendar year in proportion to the anticipated annual premium associated with each policy used in the calculation of the total bonus amount. Bonus payments are a company operating expense and, thus, are not directly reflected in the policy rate(s).

  During the course of the year, Sun Life sales and other personnel may engage in various activities with the insurance producers connected with your ERISA plan, such as "lunch and learn" meetings, restaurant meals, attending sporting events, and/or playing golf. Generally, these activities are intended to establish or strengthen the business relationship between the Sun Life sales personnel and the insurance producers and are not provided as a compensatory payment attributable to the plan's insurance contract or to the non-insurance services being provided to the plan. Accordingly, we are not reporting such expenses unless we have determined both that a particular expense is in fact a compensatory payment and exceeds the insubstantial value reporting threshold described in the Form 5500 instructions.

The enclosed should not be used for commission and/or premium reconciliation, it is strictly for Schedule A/C Form 5500 filing purposes. If you have any questions concerning this letter or enclosed information, please contact us via the above listed information.

Sincerely,
Broker Services

CC. Winton-Ireland Insurance Agency Inc

Enclosure

Sun Life Assurance of Canada is a member of the Sun Life Financial group of companies.
www.sunlife.com/us

5500 Schedule A Insurance Information

Name	Policy/Account Number	Date
Winton-Ireland Insurance Agency, Inc 627 East Canal Drive Turlock, CA 95380	247138	03/05/2018

Name of insurance carrier	EIN (Insurance Carrier)	NAIC code	Policy or Contract Year	
			From	To
Sun Life Assurance Company of Canada	38-1082080	80802	01/01/2017	12/31/2017
Contract or identification number	SEE ABOVE #	**Approximate number of persons covered at end of policy or contract year**		103

Insurance fees and commissions paid to agents, brokers, and other persons:
Total Amount of commissions paid
$69.56

Name and address of the agents, brokers or other persons to whom commissions or fees paid	Amount of commissions paid		Organization Code
	Type of Benefit	Base Commission [1]	
Winton-Ireland Insurance Agency Inc PO BOX 3277 TURLOCK, CA 95381	SA Child Voluntary AD&D	$14.57	3
	SA Spouse Voluntary AD&D	$54.99	

Total Premium received 01/01/2017 to 12/31/2017

Type of Benefit	Gross Premium
Basic LTD	$12,554.94
Child Optional Life	$581.70
Employee Basic AD&D	$877.86
Employee Basic Life	$6,583.59
Employee Optional Life	$13,347.57
SA Child Voluntary AD&D	$96.95
SA Employee Voluntary AD&D	$1,143.05
SA Spouse Voluntary AD&D	$366.44
Spouse Optional Life	$3,054.59
Total	**$38,606.69**

Comments :
Premiums/Fees **for** the time period shown above.
[1] Base Commissions paid to producer **during** the time period shown above.
Any questions in regards to commissions, bonus or awards should be directed to your producer.

Pursuant to 29 CFR 2520.103-5(c), Sun Life Assurance Company of Canada certifies that the statements above are complete and accurate.

The information reported above is for informational purposes only. It is not to be relied upon for amounts that may be due and owing with respect to the Policy.

If you have questions regarding your filing obligations, please consult with your legal and/or tax advisor.

The Hartford
GBD Producer Services
P.O.Box 2999
Hartford, CT 06104-2999

March 7, 2018

MB 01 000351 93154 H 2 A

WINTON-IRELAND INSURANCE AGENCY, INC.
LYNN M BULL
PO BOX 3277
TURLOCK CA 95381-3277

RECEIVED
03 22 18
Winton-Ireland
Strom & Green

000351 1/3

Dear Policyholder:

Attached is your certified Annual Statement of Premiums and Producer Compensation. This statement provides a concise summary of information related to your group benefits policy(ies) with The Hartford[1]. If you are required to complete and file Schedule A to IRS Form 5500, the information contained on the statement may assist you during this process. The Hartford certifies to the accuracy and completeness of the information provided.

To help you accurately read your statement, defined below are select terms used in the report:

- **Premiums** - premium payments paid and applied during the policy year.
- **Commissions** - base commissions paid to your insurance producer on premiums received and applied during the policy year.
- **Fees** - fees are other compensation paid to your insurance producer for providing administrative or other services related to your policy. If you are filing Schedule A to IRS Form 5500, **Fees** should be recorded as "Fees" on Schedule A.
- **Bonus Paid** - an allocation related to your policy or policies of contingent compensation (cash or non-cash) payable to producers on all policies that were considered in determining the producer's eligibility for bonus payments and/or the actual calculation of any such bonus payment. If you are filing Schedule A to IRS Form 5500, **Bonus Paid** should be recorded as "Fees" on Schedule A.
- **Additional Compensation** - an allocation related to your policy or policies of non-contingent compensation (cash or non-cash) payable to producers on all policies that were considered in determining the producer's eligibility for additional compensation and/or the actual calculation of any such additional compensation. If you are filing Schedule A to IRS Form 5500, **Additional Compensation** should be recorded as "Fees" on Schedule A.

We appreciate your business and look forward to continuing to serve your group benefits needs. If you need additional information, please contact your Hartford representative or call Customer Service at (800) 523-2233 or via e-mail gbdcommissions@hartfordlife.com.

Sincerely,

David Kryzanski

David R. Kryzanski
Vice President
Service Operations
P.O. Box 2999
Hartford, CT 06104-2999

[1] The Hartford ® is The Hartford Financial Services Group, Inc. and its subsidiaries.

The Hartford
Group Benefits Division
Annual Statement of Premiums and Producer Compensation

For: WINTON-IRELAND INSURANCE AGENCY, INC.

Policyholder and Address
WINTON-IRELAND INSURANCE AGENCY, INC. PO BOX 3277 TURLOCK CA 95381

Plan/Policy Year - 1/1/2017 to 12/31/2017

Name of Insurance Carrier	EIN	NAIC Code	Policy Number
HARTFORD LIFE AND ACCIDENT	06-0838648	70815	868076G

Premium was applied as follows during the Plan/Policy Year -

Policy Number	Type of Benefit	Premium Applied	Approximate # of Lives Covered
868076G	ADD-BAS	$59.93	109
868076G	ADD-SUPP	$102.55	57
868076G	LIFE-BTRM	$599.30	109
868076G	LIFE-SDEP	$452.75	81
868076G	LIFE-VOL	$1,482.18	59
868076G	LTD-ABIL	$1,605.55	27
	Total	$4,302.26	

Continued on Next Page

[1] The Hartford ® is The Hartford Financial Services Group, Inc. and its subsidiaries.

000351 2/3

The Hartford
Group Benefits Division
Annual Statement of Premiums and Producer Compensation

THE HARTFORD

For: WINTON-IRELAND INSURANCE AGENCY, INC.

Insurer paid the following on behalf of coverages shown during the Plan/Policy Year -

Producer and Address	Org Code	Policy Number	Commissions Paid	Fees Paid	(1)Bonus Paid	(2)Additional Compensation Paid
WINTON-IRELAND INS AGENCY INC PO BOX 3277 TURLOCK CA 95381	3	868076-0GL 868076-GLT	$0.00 $0.00	$0.00 $0.00	$0.00 $0.00	$0.00 $0.00
		Total	$0.00	$0.00	$0.00	$0.00

000351 3/3

(1) Bonus Paid represents an allocation of contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such bonus payment. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

(2) Additional Compensation represents an allocation of non-contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such additional compensation. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

The Hartford compensates producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation, including contingent commission and other non-cash awards. Incentive compensation is based upon a variety of factors that may include the level of premium written, retention and growth of premium, overall profitability, or other performance measures. Some of our producers elect not to accept some or all forms of compensation from The Hartford. Please direct specific questions about your insurance producer's compensation to your producer.

Form **5558**
(Rev. August 2012)

Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File Certain Employee Plan Returns

▶ For Privacy Act and Paperwork Reduction Act Notice, see instructions.
▶ Information about Form 5558 and its instructions is at *www.irs.gov/form5558*

OMB No. 1545-0212

File With IRS Only

Part I Identification

A Name of filer, plan administrator, or plan sponsor (see instructions)
WINTON-IRELAND INSURANCE AGENCY, INC.
Number, street, and room or suite no. (If a P.O. box, see instructions)
PO BOX 3277
City or town, state, and ZIP code
TURLOCK, CA 95381-3277

B Filer's identifying number (see instructions)
Employer identification number (EIN) (9 digits XX-XXXXXXX)
94-2667917
Social security number (SSN) (9 digits XXX-XX-XXXX)

C Plan name	Plan number	Plan year ending— MM	DD	YYYY
WINTON-IRELAND INSURANCE AGENCY, INC. CAFETERIA PLAN	5 0 1	12	31	2017

Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA

1 ☑ Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part 1, C above.

2 I request an extension of time until 0 9 /3 0 /2 0 1 8 to file Form 5500 series (see instructions).
Note. A signature IS NOT required if you are requesting an extension to file Form 5500 series.

3 I request an extension of time until ____/____/____ to file Form 8955-SSA (see instructions).
Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.

The application **is automatically approved** to the date shown on line 2 and/or line 3 (above) if: **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and **(b)** the date on line 2 and/or line 3 (above) is not later than the 15th day of the third month after the normal due date.

Part III Extension of Time To File Form 5330 *(see instructions)*

4 I request an extension of time until ____/____/____ to file Form 5330.
You may be approved for up to a 6 month extension to file Form 5330, after the normal due date of Form 5330.

a Enter the Code section(s) imposing the tax . . . . . ▶ a

b Enter the payment amount attached . . . . . ▶ b

c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date . . . ▶ c

5 **State in detail why you need the extension:**

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ▶ Lynn M. Bull **Date** ▶ 7/31/18