### 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	Annual Report Ide	entification Information	n				
For calend	lar plan year 2017 or fisca	l plan year beginning 08/01/2	2017	and ending 07/31/20	18		
A This re	turn/report is for:	a multiemployer plan		a multiple-employer plan (Filers checking the participating employer information in accordance)			ns.)
		a single-employer plan		a DFE (specify)			
<b>B</b> This ref	turn/report is:	the first return/report		the final return/report			
		an amended return/report	t	a short plan year return/report (less than 12	months	3)	
C If the p	lan is a collectively-bargai	ned plan, check here				. •	
<b>D</b> Check	box if filing under:	Form 5558		automatic extension	th	e DFVC program	
		special extension (enter de	escription)				
Part II	Basic Plan Inform	ation—enter all requested i	information				
1a Name of plan TRAVIS PATTERN & FOUNDRY INC EMPLOYEE HEALTH BENEFIT PLAN			1b	Three-digit plan number (PN) ▶	501		
					1c	Effective date of pla 08/01/2008	an
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 Identifi Number (EIN) 91-1403129					Number (EIN)	tion	
number						ephone	
12521 HARBOUR REACH DRIVE 12521 HARBOUR REACH DRIVE MUKILTEO, WA 98275 MUKILTEO, WA 98275			2d	Business code (see instructions) 332900	e		

#### 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.  Signature of plan administrator	01/22/2019 Date	SCOTT CHAFFIN  Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	01/22/2019	SCOTT CHAFFIN
	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

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

Form 5500 (2017) v. 170203

	Form 5500 (2017)	Page	e <b>2</b>		
3a	Plan administrator's name and address X Same as Plan Sponsor			<b>3b</b> Admir	nistrator's EIN
				3c Admin	nistrator's telephone er
				- Tidilib	OI .
4	If the name and/or EIN of the plan sponsor or the plan name has changed si	since the last retu	rn/report filed for this plan,	4b EIN	
а	enter the plan sponsor's name, EIN, the plan name and the plan number from Sponsor's name			<b>4d</b> PN	
C	Plan Name			144 114	
5	Total number of participants at the beginning of the plan year			5	338
6	Number of participants as of the end of the plan year unless otherwise state <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).	ed (welfare plans	complete only lines 6a(1),		
a(	Total number of active participants at the beginning of the plan year			6a(1)	338
a(	2) Total number of active participants at the end of the plan year				364
b	Retired or separated participants receiving benefits			_	
C	Other retired or separated participants entitled to future benefits			6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c			6d	364
е	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive benefits		6e	
f	Total. Add lines 6d and 6e.			6f	
g	Number of participants with account balances as of the end of the plan year complete this item)			. 6g	
h	Number of participants who terminated employment during the plan year wit less than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only			. 7	
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from the Lis	t of Plan Characteristics Cod	es in the ins	tructions:
h	If the plan provides welfare benefits, enter the applicable welfare feature coo	doo from the List	of Dlan Charactaristics Code	a in tha inatr	u lation a
D	4A 4E	ues nom the List	of Flati Characteristics Code	5 111 1116 111511	uctions.
9a	Plan funding arrangement (check all that apply)	9b Plan bend	efit arrangement (check all th	at apply)	
	(1) Insurance (2) Code section 412(e)(3) insurance contracts	(1)	Insurance Code section 412(e)(3)	ingurance	o ntro etc
	(2) Code section 412(e)(3) insurance contracts (3) Trust	(2) (3)	Trust	insurance c	Ontracts
	(4) X General assets of the sponsor	(4)	X General assets of the s	<u>'</u>	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, wh	nere indicated, enter the num	ber attached	I. (See instructions)
а	Pension Schedules	<b>b</b> General			
	(1) R (Retirement Plan Information)	(1)	H (Financial Infor	,	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Inforr	nation – Sm	all Plan)
	Purchase Plan Actuarial Information) - signed by the plan	(3)	A (Insurance Info	rmation)	
	actuary	(4)	C (Service Provid	er Informatio	on)

(5)

(6)

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

(3)

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

**G** (Financial Transaction Schedules)

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
2520.	plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 101-2.)
<b>11b</b> Is the	plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)
Recei	the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the pt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid pt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)
Rece	ipt Confirmation Code

Form 5500 (2017)

Page 3

# SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

**Service Provider Information** 

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 08/01/2017	and ending 07/31/2018
A Name of plan	<b>B</b> Three-digit
TRAVIS PATTERN & FOUNDRY INC EMPLOYEE HEALTH BENEFIT PLAN	plan number (PN) 501
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
TRAVIS INDUSTRIES, INC.	91-1403129
Part I   Service Provider Information (see instructions)	
You must complete this Part, in accordance with the instructions, to report the information r or more in total compensation (i.e., money or anything else of monetary value) in connectio plan during the plan year. If a person received <b>only</b> eligible indirect compensation for which answer line 1 but are not required to include that person when completing the remainder of	n with services rendered to the plan or the person's position with the h the plan received the required disclosures, you are required to
1 Information on Persons Receiving Only Eligible Indirect Compensation	tion
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of t	his Part because they received only eligible
indirect compensation for which the plan received the required disclosures (see instructions	for definitions and conditions)Yes X No
<b>b</b> If you answered line 1a "Yes," enter the name and EIN or address of each person providing received only eligible indirect compensation. Complete as many entries as needed (see instance).	structions).
(b) Enter name and EIN or address of person who provided you di	sclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you di	sclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you di	sclosures on eligible indirect compensation
(a) Enter hame and Enter address of person who promote you are	
(b) Enter name and EIN or address of name with a resulted down of	adacturas on clinible indirect companyation
(b) Enter name and EIN or address of person who provided you di	sciosures on eligible indirect compensation

Schedule C (Form 5500) 2017	Page <b>2-</b> 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 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>b</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 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	no provided you disclosures on eligible indirect compensation

	Schedule C (Form 550	00) 2017		Page <b>3 -</b> 1			
answered	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 CH	OICE HEALTH			X 94041 .E, WA 98124			
(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?	(g) 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?	
13	ADM. SVC. PROVIDER	121737	Yes No 🗵	Yes No		Yes No	
		(	a) Enter name and EIN or	address (see instructions)			
(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?	
			Yes No No	Yes No		Yes No	
		(1	a) Enter name and EIN or	address (see instructions)			
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be	Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required	Enter total indirect compensation received by service provider excluding eligible indirect	(h) Did the service provider give you a formula instead of an amount or	

sponsor)

Yes No

disclosures?

Yes No

answered "Yes" to element (f). If none, enter -0-.

compensation for which you estimated amount?

Yes No

a party-in-interest

Page	3 -	2
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answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
	, , ,			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
		(	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

D( II		No. 2011 1. 1. 1				
this Schedule.		h service provide	r who failed or refused to provide the information necessary to complete			
(a) Enter name and El	N 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 El	N 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 El	N 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 El	N 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 El	N 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 El	N 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

Pa	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)					
	(complete as many entries as needed)					
а	Name:	b EIN:				
С	Position:					
d	Address:	<b>e</b> Telephone:				
u	Address.	С теюрионе.				
Ex	planation:					
а	Name:	<b>b</b> EIN:				
С	Position:					
d	Address:	e Telephone:				
<b>-</b>		- 1.5.5priorio.				
	nlanation:					
⊏X	planation:					
а	Name:	<b>b</b> EIN:				
С	Position:					
d	Address:	e Telephone:				
		·				
Ex	planation:					
a	Name:	<b>b</b> EIN:				
C	Position:					
d	Address:	<b>e</b> Telephone:				
Ex	planation:					
а	Name:	<b>b</b> EIN:				
C	Position:	₩ LIIV.				
d		<b>e</b> Telephone:				
u	Address:	с тетернопе:				
Ex	planation:					

## 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** 

Pa	rt I Annual Report Identification In	ormation						
	For calendar plan year 2017 or fiscal plan year beginning $08/01/2017$ and ending $07/31/2018$							
Α .	This return/report is for: a multiemployer pl	an aı	multiple-employer plan (File	e-employer plan (Filers checking this box must attach a list of				
В	a single-employer the first return/rep	pa plan a [] a [	participating employer information in accordance with the form instr.)  a DFE (specify) the final return/report					
	an amended return			ort (less than 12 months)				
C	f the plan is a collectively-bargained plan, check here	snort plan year return/repo	DOIT (less than 12 months)					
D (	Check box if filing under: Form 5558	☐ au	tomatic extension	the DFVC program				
special extension (enter description)   Part II   Basic Plan Information - enter all requested information								
TR	Name of plan AVIS PATTERN & FOUNDRY INC	1b Three-digit plan number (PN) ▶ 501						
	PLOYEE HEALTH BENEFIT PLAN	Effective date of plan 08/01/2008						
Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box)				$\begin{array}{ll} \textbf{2b} & \text{Employer Identification Number (EIN)} \\ & 91-1403129 \end{array}$				
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) TRAVIS INDUSTRIES, INC.				2c Plan Sponsor's telephone number $425-609-2500$				
12521 HARBOUR REACH DRIVE				2d Business code (see instructions) 332900				
MUI	KILTEO WA							
Caut	ion: A penalty for the late or incomplete filing of t	his return/report will	be assessed unless reas	sonable cause is established				
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.								
SIGI	E row Cheetin	1-22-19	SCOTT CHAFFIN					
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator					
SIGI	E DECTION OF CHILD	/-22-/9 Date	SCOTT CHAFFI					
	Signature of employer/plan sponsor	Enter name of individual	dual signing as employer or plan sponsor					

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

Date

Form 5500 (2017) v. 170203

SIGN HERE

Signature of DFE

Enter name of individual signing as DFE

	Form 5500 (2017)		Page 2			
3a	Plan administrator's name and address X Same as Plan Sponsor 3b Adminis		trator's EIN			
	A.	3c Administra			ator's telephone number	
4	If the name and/or EIN of the plan sponsor or the plan name has chan enter the plan sponsor's name, EIN, the plan name and the plan number				plan, 4b EIN	
	Sponsor's name Plan Name				4d PN	
5	Total number of participants at the beginning of the plan year		×	5		338
6	Number of participants as of the end of the plan year unless otherwise	e stated (welfare plans com	plete only lines			
2	6a(1), 6a(2), 6b, 6c, and 6d).			6a(1)		
a	a (1) Total number of active participants at the beginning of the plan year					338
b	(2) Total number of active participants at the end of the plan year  Retired or separated participants receiving benefits			6a(2)	<b></b>	364
C	Other retired or separated participants entitled to future benefits	***************************************		6b 6c		
d	Subtotal. Add lines 6a(2), 6b, and 6c			6d		364
е	Deceased participants whose beneficiaries are receiving or are entitled			6e		304
f	Total. Add lines <b>6d</b> and <b>6e</b>		••••••••••	6f		
g	Number of participants with account balances as of the end of the pla	n year (only defined contrib	oution plans	-		
	complete this item)	omplete this item)  lumber of participants who terminated employment during the plan year with accrued benefits that were				
h	Number of participants who terminated employment during the plan year					
7	less than 100% vested			6h		
′	Enter the total number of employers obligated to contribute to the plar this item)			_		
8a	this item)  If the plan provides pension benefits, enter the applicable pension feat	ture codes from the List of	Dian Characteries	7	l	
b 4A	If the plan provides welfare benefits, enter the applicable welfare featu $4\mathtt{E}$					
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrang	jement (check all	that ap	ply)	
	(1) Insurance	(1) Insurance				
	(2) Code section 412(e)(3) insurance contracts Trust	1777 - A-1004	tion 412(e)(3) inst	urance (	contracts	
	(4) X General assets of the sponsor	(3) Trust				
10	Check all applicable boxes in 10a and 10b to indicate which schedules	(4) A General a	ssets of the spon	bo num	har attaches	
	(See instructions)	are attached, and, where	indicated, enter t	ne num	ber attached	1.
a	Pension Schedules	b General Schedule	s			
	(1) R (Retirement Plan Information)	(1) H	(Financial Inf	ormatio	n)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	(Financial Inf			n)
	Purchase Plan Actuarial Information) - signed by the plan	(3) A				•
	actuary	(4) X C	(Service Prov	ider Inf	ormation)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) D	(DFE/Particip	ating P	lan Informati	on)
	Information) - signed by the plan actuary	(6) 📙 G	(Financial Tra	ansactio	n Schedules	s)

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.)  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.)	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					