## Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## Annual Return/Report of Employee Benefit Plan

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

▶ Complete all entries in accordance with the instructions to the Form 5500. OMB Nos. 1210-0110 1210-0089

2018

_	Administration	the instructi									
Pensio	on Benefit Guaranty Corporation		This Form is Open to Pub Inspection	lic							
Part I Annual Report Identification Information											
For cale	For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018										
A This return/report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this box must attach a participating employer information in accordance with the form in											
<b>B</b> This	return/report is:	the first return/report	the final return/	report/report							
		an amended return/report	a short plan ye	ar return/report (less than 12	2 months)						
C If the	plan is a collectively-bargain	ned plan, check here									
<b>D</b> Chec	k box if filing under:	Form 5558	automatic exten	sion	the DFVC program						
	special extension (enter description)										
Part II	Basic Plan Inform	ation—enter all requested informatio	n								
1a Nam	ne of plan LE INDIAN HEALTH BOARI	<b>1b</b> Three-digit plan number (PN) ▶	501								
02/1111					1c Effective date of plan 01/01/1984	ı					
Mail City	ing address (include room, a or town, state or province, c	, if for a single-employer plan) apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code	(if foreign, see instru	uctions)	2b Employer Identification Number (EIN) 91-0869056	Number (EIN)					
SEATTLE	E INDIAN HEALTH BOARD				2c Plan Sponsor's telephone number 206-324-9360						
PO BOX SEATTLE	3364 E, WA 98114-3364	611 12TH AVE S. SEATTLE, WA 98144			2d Business code (see instructions) 621399						
Caution	: A penalty for the late or i	ncomplete filing of this return/report	t will be assessed ι	unless reasonable cause is	s 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	Filed with authorized/valid	electronic signature.	07/24/2019	PAMELA GRINDLEY							
HERE	Signature of plan admini	strator	Date	Enter name of individual s	igning as plan administrator						
SIGN											

Date

Date

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

Signature of employer/plan sponsor

Signature of DFE

**HERE** 

SIGN HERE

> Form 5500 (2018) v. 171027

Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

Form 5500 (2018) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN **3c** Administrator's telephone number 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, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **4d** PN Sponsor's name Plan Name Total number of participants at the beginning of the plan year 163 5 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). 161 a(1) Total number of active participants at the beginning of the plan year ...... 6a(1) 190 a(2) Total number of active participants at the end of the plan year ...... 6a(2)Retired or separated participants receiving benefits..... 6b 0 6c Other retired or separated participants entitled to future benefits...... 191 6d Subtotal. Add lines 6a(2), 6b, and 6c..... Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item) ..... Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested ..... 6h

1	Enter the t	otal number of employers obligated to contribute to the plan (only	multiemplo	yer plans	complete this item)			
8a	If the plan	provides pension benefits, enter the applicable pension feature co	des from th	ne List of F	Plan Characteristics Codes in the instructions:			
b	•	provides welfare benefits, enter the applicable welfare feature cod 4D 4E 4H 4L 4Q	les from the	e List of Pl	an Characteristics Codes in the instructions:			
9a	Plan fundir	ng arrangement (check all that apply)	<b>9b</b> Plar	n benefit a	rrangement (check all that apply)			
	(1) X	Insurance	(1)	X	Insurance			
	(2)	Code section 412(e)(3) insurance contracts	(2)	П	Code section 412(e)(3) insurance contracts			
	(3)	Trust	(3)	П	Trust			
	(4) X	General assets of the sponsor	(4)	X	General assets of the sponsor			
10	Check all a	applicable boxes in 10a and 10b to indicate which schedules are a	ttached, ar	nd, where	indicated, enter the number attached. (See instructions)			
а	Pension S	chedules	b General Schedules					
	(1)	R (Retirement Plan Information)	(1)		H (Financial Information)			
			(2)	П	I (Financial Information – Small Plan)			
	(2)	<b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3)	X	_6_ A (Insurance Information)			
		actuary	(4)	П	C (Service Provider Information)			
	(3)	SB (Single-Employer Defined Benefit Plan Actuarial	(5)		<b>D</b> (DFE/Participating Plan Information)			
	` , _	Information) - signed by the plan actuary	(6)		<b>G</b> (Financial Transaction Schedules)			

Form 5500 (2018)

Page 3

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)							
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)							
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)							
11c Enter the Receipt Confirmation Code for the 2018 Form M-1 annual report. If the plan was not required to file the 2018 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							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

,	This Form is Open to Public Inspection						
For calendar plan year 20	18 or fiscal pla	an year beginning 01/01/2018		and en	iding 12/31	/2018	
A Name of plan SEATTLE INDIAN HEAL INSURANCE PLAN	TH BOARD M	EDICAL, DENTAL, LIFE/AD&D 8	& DISABILITY		e-digit number (PN	) <b>&gt;</b>	501
C Plan sponsor's name as shown on line 2a of Form 5500 SEATTLE INDIAN HEALTH BOARD  D Employer Identification Number (E 91-0869056							
		rning Insurance Contract  A. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		OF WASHINGTON	(2) A		I	Daliana	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a policy or contract	end of	(f)	From	contract year (g) To
91-0511770	95672	1654200	79		01/01/2018		12/31/2018
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	tal commissions paid. Li	st in line 3	the agents, b	rokers, and	other persons in
(a) Total							
(a) Total amount of commissions paid (b) Total amount of fees paid 28493							0
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name	and address of the agent, broker	r, or other person to whor	n commiss	ions or fees v	vere paid	
DIGITAL INSURANCE INC		STE 1	ALLERIA PKWY 950 NTA, GA 30339				
(b) Amount of sales a	nd hase	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	28493						3
	(a) Name	and address of the agent, broker	r, or other person to whor	n commiss	ions or fees v	vere paid	
(b) Amount of sales a			es and other commission				(1) 0
commissions pa	Ia	(c) Amount	(	(d) Purpose	<del>U</del>		(e) Organization code

Schedule A (Form 5500) 2018 Page <b>2 –</b> 1						
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
		From and other constitutions and	(-)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
	T					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
, ,	<u> </u>					
		Fees and other commissions paid	(e)			
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
•						
(a) Na	The standard of the stand business					
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
<b>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization			
commissions paid	(0)	(a) supers	code			
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
	T		1			
(h) Amount of sales and hase		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code			
			Organization			

F	Part	Investment and Annuity Contract Information			
•	urt	Where individual contracts are provided, the entire group of such indivi	dual contracts with each of	arrier may be treated as a uni	t for purposes of
1	Cur	this report.	and	4	
		rent value of plan's interest under this contract in the general account at year or Tent value of plan's interest under this contract in separate accounts at year er			
_		tracts With Allocated Funds:	<u> </u>	<b>J</b>	
Ŭ	a	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	• 🗆	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>	7d	0
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		<b>&gt;</b>			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			0

Pa	art	Ш	Welfare Benefit Contract Informa	ation						
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ting purpos	ses if such cont	racts are exp	erience-rated as a	unit. Where co	ontracts cover indivi	
8	Ben	efit a	and contract type (check all applicable boxes)							
	а	X He	ealth (other than dental or vision)	<b>b</b> De	ental	С	Vision		<b>d</b> Life insurance	е
	еĪ	Te	emporary disability (accident and sickness)	f 🗆 Lo	ng-term disabili	ty <b>g</b>	Supplemental un	emplovment	h Prescription	drua
	i [	=	op loss (large deductible)		//O contract	· - <u>-</u>	PPO contract		I Indemnity co	-
	· [			, L	no contract	<b>"</b> L	1 1 0 contract			illaot
	m	_ 0	ther (specify)							
α .	Evn	orion	ce-rated contracts:							
			niums: (1) Amount received			9a(1)			_	
	<b>-</b>		ncrease (decrease) in amount due but unpaid							
			ncrease (decrease) in unearned premium res							
			Earned ((1) + (2) - (3))					9a(4)		C
	b	. ,	nefit charges (1) Claims paid							
		(2) I	ncrease (decrease) in claim reserves							
		(3) I	ncurred claims (add (1) and (2))					9b(3)		0
		(4) (	Claims charged					9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	n an accru	ual basis)					
			(A) Commissions			9c(1)(A)				
			(B) Administrative service or other fees			0 (4)(0)			_	
			(C) Other specific acquisition costs			0. (4)(D)				
			(D) Other expenses							
			(E) Taxes			90(1)(E)			_	
			(F) Charges for risks or other contingencies. (G) Other retention charges			9c(1)(F)				
			(H) Total retention(H)					9c(1)(H)	1	
			Dividends or retroactive rate refunds. (These						<b>/</b>	
	d		tus of policyholder reserves at end of year: (1		_					
	u		Claim reserves					9d(1) 9d(2)		
		` '	Other reserves							
	е	` '	dends or retroactive rate refunds due. (Do n							
10	No		perience-rated contracts:				, ,	•		
	а	Tota	al premiums or subscription charges paid to o	arrier				10a		597279
	b Spe	rete	e carrier, service, or other organization incur- ention of the contract or policy, other than rep- nature of costs.	, ,			•			
	Орс	iony i								
Pa	art	IV	Provision of Information							
11	Dio	d the	insurance company fail to provide any inform	nation nec	essary to comp	lete Schedule	e A?	Yes	X No	
			nswer to line 11 is "Yes," specify the informat			2,2 23				
		. 10 ui	13 mile 11 is 153, opening the militaria	not pro						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

				s are required to provide to c ERISA section 103(a)(2)		lion	This Fo	rm is Open to Public Inspection			
For calendar p	olan year 20	18 or fiscal plant	an year beginning 01/01/2018		and en	nding 12/3	1/2018				
A Name of p SEATTLE INI INSURANCE	DIAN HEAL	TH BOARD M	IEDICAL, DENTAL, LIFE/AD&D	& DISABILITY		e-digit number (PN	I) <b>&gt;</b>	501			
	C Plan sponsor's name as shown on line 2a of Form 5500 SEATTLE INDIAN HEALTH BOARD  D Employer Identification Number (E 91-0869056										
Part I	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.										
1 Coverage I	nformation:										
(a) Name of it			OF WASHINGTON OPTIONS,		wal an of		Dollovoro	antrost vest			
(b) E	EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate not persons covered a policy or contract	t end of	(f)	From	contract year  (g) To			
91-1467158		47055	8161700	114	•	01/01/2018	3	12/31/2018			
		mission inform	nation. Enter the total fees and t	total commissions paid. L	ist in line 3	the agents, I	brokers, and o	other persons in			
(a) Total amount of commissions paid (b) Total amount of fees paid											
41409							8				
3 Persons re	ceiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).						
			and address of the agent, broke		m commiss	ions or fees	were paid				
DIGITAL INSU	IRANCE INC		STE	GALLERIA PKWY 1950 ANTA, GA 30339							
<b>(b)</b> Amour	nt of sales ar	nd base	F	ees and other commissio	ns paid						
` '	missions pa		(c) Amount		(d) Purpose	е		(e) Organization code			
		41409	8	NON-MONETARY				3			
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid				
	nt of sales ar			ees and other commissio	ns paid (d) Purpose	<u> </u>		(a) Organization code			
commissions paid (c) Amount					(a) i diposi			(e) Organization code			

Schedule A (Form 5500) 2018 Page <b>2 –</b> 1						
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
		From and other constitutions and	(-)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
	T					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
, ,	<u> </u>					
		Fees and other commissions paid	(e)			
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
•						
(a) Na	The standard of the stand business					
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
<b>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization			
commissions paid	(0)	(a) supers	code			
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
	T		1			
(h) Amount of sales and hase		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code			
			Organization			

F	Part	Investment and Annuity Contract Information			
•	urt	Where individual contracts are provided, the entire group of such indivi	dual contracts with each of	arrier may be treated as a uni	t for purposes of
1	Cur	this report.	and	4	
		rent value of plan's interest under this contract in the general account at year or tent value of plan's interest under this contract in separate accounts at year er			
_		tracts With Allocated Funds:	<u> </u>	<b>J</b>	
Ŭ	a	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	• 🗆	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>	7d	0
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		<b>&gt;</b>			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			0

P	art	Ш	Welfare Benefit Contract Informa	ation									
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ting pur	rpose	s if such c	ontracts a	re exp	erience-rated as	s a unit.	. Where co	ontracts	s cover individual
8	Ben	efit a	nd contract type (check all applicable boxes)										
	а	X He	ealth (other than dental or vision)	b∏	Denta	al		С	Vision			d□	Life insurance
	еĪ	_   Τε	emporary disability (accident and sickness)	fΠ	Lona	j-term disa	bility	g	Supplemental	lunemo	olovment	hП	Prescription drug
	i [	=	op loss (large deductible)		_	contract	,		PPO contract		,		Indemnity contract
	. [			, <sub>□</sub>	TIIVIO	Contract		" L	] 11 0 contract			•□	macming contract
	m	_ 0	ther (specify)										
<u> </u>	Evn	orion	ce-rated contracts:										
3			iums: (1) Amount received				9a	11)				_	
	<b>-</b>		ncrease (decrease) in amount due but unpaid									_	
			ncrease (decrease) in unearned premium res										
			Earned ((1) + (2) - (3))								9a(4)		(
	b	. ,	efit charges (1) Claims paid										
		(2) li	ncrease (decrease) in claim reserves										
		(3) li	ncurred claims (add (1) and (2))								9b(3)		0
		(4) (	Claims charged								9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	n an ac	ccrual	l basis)							
			(A) Commissions										
			(B) Administrative service or other fees				- 77						
			(C) Other specific acquisition costs				0.74						
			(D) Other expenses									_	
			(E) Taxes				90(1	)( <b>-</b> )				_	
			(F) Charges for risks or other contingencies (G) Other retention charges				90(1	)(F)				_	
			(H) Total retention(H) Total retention								9c(1)(H)	\ <u> </u>	(
			Dividends or retroactive rate refunds. (These									<del>'</del>	
	d		us of policyholder reserves at end of year: (1								9c(2) 9d(1)		
	u		Claim reserves								9d(1)		
		` '	Other reserves								9d(3)		
	е	` '	dends or retroactive rate refunds due. (Do n								9e		
10	No		erience-rated contracts:						,				
	а	Tota	al premiums or subscription charges paid to o	arrier							10a		904930
	<b>b</b> Spe	rete	e carrier, service, or other organization incur ntion of the contract or policy, other than rep nature of costs.	•	•						10b		
	Орс	iony i	initial of costs.										
Pa	art	IV	Provision of Information										
11	Dio	d the	insurance company fail to provide any inform	nation n	neces	sary to cor	nplete Sc	hedule	A?	П	Yes	X No	)
			nswer to line 11 is "Yes," specify the informat				F. 2.20 DO						
-	(	. 10 ui	to mile i i io i oposity the militati	.5 1101	, p. 0 v i								

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

#### File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

	m is Open to Public Inspection						
For calendar plan year 20	18 or fiscal pla	in year beginning 01/01/2018		and en	ding 12/3	1/2018	
A Name of plan SEATTLE INDIAN HEALT INSURANCE PLAN	TH BOARD ME	EDICAL, DENTAL, LIFE/AD&D (	& DISABILITY		e-digit number (PN	I) <b>&gt;</b>	501
C Plan sponsor's name as shown on line 2a of Form 5500 SEATTLE INDIAN HEALTH BOARD  D Employer Identification Number (E 91-0869056							(EIN)
		rning Insurance Contract  A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca DELTA DENTAL OF WASI							
/L) FINI	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or c	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
91-0621480	47341	06223	217	•	01/01/2018	3	12/31/2018
2 Insurance fee and come descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, I	brokers, and o	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
13585 0							0
3 Persons receiving com	missions and f	fees. (Complete as many entrie	s as needed to report all	persons).			
		and address of the agent, broke	·		ions or fees	were paid	
DIGITAL INSURANCE INC	C. ANDONIAN		WOLLOCHET DR NW HARBOR, WA 98335				
(b) Amount of sales ar	nd hase	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code
	13585						3
	(a) Name a	and address of the agent, broke	r. or other person to who	m commissi	ions or fees	were paid	
	(4)		,				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part	Investment and Annuity Contract Information			
•	urt	Where individual contracts are provided, the entire group of such indivi	dual contracts with each of	arrier may be treated as a uni	t for purposes of
1	Cur	this report.	and	4	
		rent value of plan's interest under this contract in the general account at year or tent value of plan's interest under this contract in separate accounts at year er			
_		tracts With Allocated Funds:	<u> </u>	<b>J</b>	
Ŭ	a	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	• 🗆	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>	7d	0
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		<b>&gt;</b>			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			0

Pa	art	III Welfare Benefit Contract Informat	ion			
		If more than one contract covers the same guthe information may be combined for reporting employees, the entire group of such individual.	ng purposes if such contr	racts are expe	erience-rated as a unit. Where	contracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)				
	а	—	<b>b</b> X Dental	С	Vision	<b>d</b> Life insurance
	e [		f ☐ Long-term disabilit		Supplemental unemployment	
				· - <u>-</u>		
	ַ י	Stop loss (large deductible)	j  HMO contract	k_	PPO contract	I Indemnity contract
	m	Other (specify)				
_						
		perience-rated contracts:	,	2 (1)		
	а	Premiums: (1) Amount received	ľ	9a(1)	1377	
		(2) Increase (decrease) in amount due but unpaid.		9a(2)		0
		(3) Increase (decrease) in unearned premium rese	•		0-/4	0
	h	(4) Earned ((1) + (2) - (3))				
	b	Benefit charges (1) Claims paid	ľ	` '	958	
		(2) Increase (decrease) in claim reserves(3) Incurred claims (add (1) and (2))			-10 	
		(4) Claims charged				<b>,</b>
	С	Remainder of premium: (1) Retention charges (on			<u>JD(</u> +	34002
	C	(A) Commissions	·	9c(1)(A)	135	85
		(B) Administrative service or other fees	ľ		176	
		(C) Other specific acquisition costs	ľ	9c(1)(C)	170	0
		(D) Other expenses	ľ	0 (4)(D)		0
		(E) Taxes				0
		(F) Charges for risks or other contingencies		9c(1)(F)		0
		(G) Other retention charges		9c(1)(G)		0
		(H) Total retention			9c(1)(	<b>H)</b> 31275
		(2) Dividends or retroactive rate refunds. (These a	amounts were paid in	cash, or	credited.)9c(2	)
	d	Status of policyholder reserves at end of year: (1)	_			
		(2) Claim reserves			9d(2	5000
		(3) Other reserves			9d(3	)
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	l in line <b>9c(2)</b> .	) 9e	C
10	No	onexperience-rated contracts:				
	а	Total premiums or subscription charges paid to ca	rrier		10a	C
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than repor				
D:	art I	IV Provision of Information				
		id the insurance company fail to provide any informa		ete Schedule	A? Yes	X No
12	If t	the answer to line 11 is "Yes," specify the informatio	n not provided.			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

	,	•	ERISA section 103(a)(2)		ION	This Fo	orm is Open to Public Inspection
For calendar plan year 20	18 or fiscal pla	n year beginning 01/01/2018		and en	ding 12/31	/2018	
A Name of plan SEATTLE INDIAN HEALT INSURANCE PLAN	ΓΗ BOARD MI	EDICAL, DENTAL, LIFE/AD&D 8	& DISABILITY		e-digit number (PN	) •	501
C Plan sponsor's name a SEATTLE INDIAN HEALT	TH BOARD			91-0	oyer Identifica 0869056		
		rning Insurance Contract  A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca VISION SERVICE PLAN	rrier		(e) Approximate nu	umbar of		Policy or	contract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	t end of	(f)	From	(g) To
23-7089668	53031	30073268	154	•	01/01/2018		12/31/2018
2 Insurance fee and com- descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, b	rokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
1023 0							
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name	and address of the agent, broke	r, or other person to whor	n commiss	ions or fees v	were paid	
DIGITAL INSURANCE, INC	C	STE 1	ALLERIA PKWY SE 950 NTA, GA 30339-5946				
(b) Amount of sales ar	nd hase	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	1023						3
	(a) Name	and address of the agent, broke	r, or other person to whor	n commiss	ions or fees v	were paid	
(b) Amount of sales ar			ees and other commission	•			
commissions pa	ıd	(c) Amount		(d) Purpose	9		(e) Organization code

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part	Investment and Annuity Contract Information			
•	urt	Where individual contracts are provided, the entire group of such indivi	dual contracts with each of	arrier may be treated as a uni	t for purposes of
1	Cur	this report.	and	4	
		rent value of plan's interest under this contract in the general account at year or tent value of plan's interest under this contract in separate accounts at year er			
_		tracts With Allocated Funds:	<u> </u>	<b>J</b>	
Ŭ	a	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	• 🗆	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>	7d	0
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		<b>&gt;</b>			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			0

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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2018

This Form is Open to Public

		pursuant to EF	RISA section 103(a)(2).		11110	Inspection		
For calendar plan year 20	18 or fiscal plar	n year beginning 01/01/2018		and ending	12/31/2018			
A Name of plan SEATTLE INDIAN HEALT INSURANCE PLAN	ΓΗ BOARD ME	DICAL, DENTAL, LIFE/AD&D & D	DISABILITY	Three-dig plan num		501		
C Plan sponsor's name as shown on line 2a of Form 5500 SEATTLE INDIAN HEALTH BOARD  D Employer Identification Number (EIN) 91-0869056								
		rning Insurance Contract of Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca		OF AMERICA						
	(c) NAIC	(d) Contract or	(e) Approximate number		Policy	or contract year		
(b) EIN	code	identification number	persons covered at en- policy or contract yea		(f) From	<b>(g)</b> To		
22-1211670	68241	02046	188	01/0	01/2018	12/31/2018		
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	commissions paid. List in	n line 3 the a	igents, brokers, ar	nd other persons in		
(a) Total a	amount of com			(b) Total a	mount of fees paid			
		7170				58		
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all pers	sons).				
		and address of the agent, broker, o		ommissions	or fees were paid			
DIGITAL INSURANCE INC	;		950 LERIA PKWY 'A, GA 30339					
(b) Amount of sales ar	nd base	Fees	and other commissions pa	aid				
commissions pai		(c) Amount	(d) F	Purpose		(e) Organization code		
	7170					3		
	(a) Name a	and address of the agent, broker, o	or other person to whom co	ommissions	or fees were paid			
AXA ASSISTANCE, USA		122 SOL SUITE 1	JTH MICHIGAN AVENUE		·			
(b) Amount of sales ar	nd base	Fees	and other commissions pa	aid				
commissions pai		(c) Amount		Purpose		(e) Organization code		
		58 TH	IRD PARTY ADMINISTRA	ATION FEES	<b>S</b>	5		

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1	
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
( <b>a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part	Investment and Annuity Contract Information			
•	urt	Where individual contracts are provided, the entire group of such indivi	dual contracts with each of	arrier may be treated as a uni	t for purposes of
1	Cur	this report.	and	4	
		rent value of plan's interest under this contract in the general account at year or tent value of plan's interest under this contract in separate accounts at year er			
_		tracts With Allocated Funds:	<u> </u>	<b>J</b>	
Ŭ	a	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	• 🗆	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	. 7c(5)		
		•			
		(6)Total additions		7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>	7d	0
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		<b>&gt;</b>			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			0

P	art	Ш	Welfare Benefit Contract Inform	ation	1								
			If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	ting pu	urpos	es if such	contra	cts are exp	per	ience-rated as a un	it. Where	contract	ts cover individual
8	Ben	efit a	and contract type (check all applicable boxes)										
	а	Не	ealth (other than dental or vision)	b	Der	ntal		С	1	Vision		d X	Life insurance
	еĪ	=	emporary disability (accident and sickness)	f X	Lon	na-term dis	sahility	g	=	Supplemental unen	nnlovment	h⊟	Prescription drug
	. [	=	op loss (large deductible)	. <u>~</u>	_	O contract	-			PPO contract			Indemnity contract
	' [			ר ו	J			<u>L</u>		FFO COILLACE		•⊔	indenning contract
	m	X O	ther (specify) AD&D, VOL LIFE, VOL DEF	LIFE	SPU	JUSE/FAIV	I, VOL	CHILD LIF	-E				
<u> </u>	Evn	orion	ce-rated contracts:										
3			niums: (1) Amount received					9a(1)	T				
	<b>-</b>		ncrease (decrease) in amount due but unpai				<b>—</b>	9a(2)	1				
			ncrease (decrease) in unearned premium res					9a(3)					
			Earned ((1) + (2) - (3))								9a(4)		(
	b		nefit charges (1) Claims paid					9b(1)					
			ncrease (decrease) in claim reserves					9b(2)					
		(3) li	ncurred claims (add (1) and (2))								9b(3)	)	(
		(4) (	Claims charged								9b(4)	1	
	С	Ren	nainder of premium: (1) Retention charges (	n an a	accru	ıal basis) -	-						
			(A) Commissions				<u> </u>	9c(1)(A)					
			(B) Administrative service or other fees					9c(1)(B)	1				
			(C) Other specific acquisition costs					9c(1)(C)	-				
			(D) Other expenses					9c(1)(D)	-				
			(E) Taxes				······  <u>`</u>	9C(1)(E)	+				
			(F) Charges for risks or other contingencies.					2C(1)(F)					
			(G) Other retention charges						<u> </u>		9c(1)(H	1/	
			(H) Total retention  Dividends or retroactive rate refunds. (These										
	a												
	d		tus of policyholder reserves at end of year: (1 Claim reserves								9d(1) 9d(2)		
		` '	Other reserves										
	е	. ,	dends or retroactive rate refunds due. (Do n										
10	No		perience-rated contracts:						,,				
	а		al premiums or subscription charges paid to	carrier							10a		71698
	b	rete	e carrier, service, or other organization incur ention of the contract or policy, other than rep							•	10b		
	Spe	cify r	nature of costs.										
Pa	art	IV	Provision of Information										
11	Dic	d the	insurance company fail to provide any inform	nation	nece	essary to c	omplet	e Schedule	e <i>P</i>	٨?	Yes	X N	0
12	If t	he ar	nswer to line 11 is "Yes," specify the informat	ion no	t pro	vided.							

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

2018

This Form is Open to Public Inspection

For calendar plan year 20°	18 or fiscal plar	year beginning 01/01/2018		and en	iding 12/31/2018		
A Name of plan SEATTLE INDIAN HEALT INSURANCE PLAN	TH BOARD ME	DICAL, DENTAL, LIFE/AD&D &	DISABILITY	3 Three plan	e-digit number (PN)	501	
C Plan sponsor's name a SEATTLE INDIAN HEALT		e 2a of Form 5500	С		oyer Identification Number 0869056	(EIN)	
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance car COLONIAL LIFE & ACCIDI		CE COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate num		Policy or c	or contract year	
(b) EIN	code	identification number	persons covered at e policy or contract y		(f) From	<b>(g)</b> To	
57-0144607	62049	E8936759	33		01/01/2018	12/31/2018	
2 Insurance fee and community descending order of the		ation. Enter the total fees and tot	al commissions paid. List	in line 3	the agents, brokers, and c	ther persons in	
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount of fees paid		
		1511				127	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all pe	ersons).			
	(a) Name a	nd address of the agent, broker,	or other person to whom o	commiss	ions or fees were paid		
DIGITAL INSURANCE LLC	)		ALLERIA PARKWY ITA, GA 30339				
		ATEAN	VIA, OA 30000				
(b) Amount of sales an	nd base	Fee	es and other commissions	paid			
commissions pai		(c) Amount	(d)	(e) Organization code			
	529	8 F	EES			3	
	(a) Name a	nd address of the agent, broker.	or other person to whom o	commiss	ions or fees were naid	-	
JOEL N NEWMAN AGENO			LAKE CITY WAY NE	COMMINISS	ions of fees were paid		
			TLE, WA 98125				
(b) Amount of sales an	nd hase	Fee	es and other commissions	paid			
commissions pai		(c) Amount	` ,	) Purpose	e	(e) Organization code	
	360	97 F	EES			3	
For Paperwork Reduction	n Act Notice. s	see the Instructions for Form	5500.		Sche	dule A (Form 5500) 2018	

Schedule A (Form 5500) 2018		Page <b>2 –</b> 1				
(a) Nan	ne and address of the agent, broker	, or other person to whom commissions or fees were paid				
CALEB ANTHONY LAW						
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
161	13	FEES	3			
	ne and address of the agent, broker	, or other person to whom commissions or fees were paid				
BRIAN T MURPHY LLC		47TH AVE SW TLE, WA 98136				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
143	8	FEES	3			
(a) Non	and address of the agent broker	, or other person to whom commissions or fees were paid	<u>.</u>			
KATHLEEN COLLINS		SW HENDERSON ST TLE, WA 98106				
(b) Amount of sales and base		Fees and other commissions paid (e) Organiza				
commissions paid	(c) Amount	(d) Purpose	code			
105			3			
(a) Nan	ne and address of the agent, broker	, or other person to whom commissions or fees were paid				
WHITFIELD BENEFIT SOLUTIONS	341 W	7. TUDOR ROAD IORAGE, AK 99503				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
102			3			
<b>(a)</b> Nan	ne and address of the agent, broker	, or other person to whom commissions or fees were paid				
KELSEY LAINE WATKINS	725 S EDMC	PRUCE STREET DNDS, WA 98020				
Fees and other commissions paid (e)			(e)			
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose		Organization code				

Page	2	_	2

<b>(a)</b> Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
DANIEL PAEK		SOUTH 87TH STREET DMA, WA 98444				
	17.00	7, 17, 100-1-1				
	Fees and other commissions paid (e) Organization					
(b) Amount of sales and base commissions paid	ount of sales and base ommissions paid (c) Amount (d) Purpose					
38			3			
LAURABETH CHRISTENSEN		r, or other person to whom commissions or fees were paid 7 2ND DR SE				
LAURADETTI CHRISTENSEN	BOTH	HELL, WA 98012				
	<u> </u>	Can and other commissions until	(a)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
18	1	FEES	3			
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
ZINA OSTER	3153 I	FOREST DR				
	CHEY	/ENNE, WY 82001				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
14	, ,	(, ,	3			
( <b>a)</b> Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid				
	Τ					
(b) Amount of sales and base	Fees and other commissions paid (e) Organization					
commissions paid	(c) Amount	(d) Purpose	code			
(a) No.	me and address of the agent broker	ar other nersen to whom commissions or feed were noid	1			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid				
Fees and other commissions paid (e)						
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization			
commissions paid	(e) Amount	(u) i dipose	code			

F	Part	Investment and Annuity Contract Information			
•	urt	Where individual contracts are provided, the entire group of such indivi	dual contracts with each of	arrier may be treated as a uni	t for purposes of
1	Cur	this report.	and	4	
		rent value of plan's interest under this contract in the general account at year or tent value of plan's interest under this contract in separate accounts at year er			
_		tracts With Allocated Funds:	<u> </u>	<b>J</b>	
Ŭ	a	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	<b>▶</b> □	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) guaranteed investment (4) other			
		(,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,,			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year			
		(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)		
		<b>)</b>			
		(6)Total additions		7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).	<u></u>	7d	0
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		<b>&gt;</b>			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			0

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## 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

2018

This Form is Open to Public

					Inspection
Part I		Identification Information			
For calen	For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018				
A This re	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 r	eturn/report is:	the first return/report	the final return/	report	
an amended return/report a short plan year return/report (less than 12 months)					2 months)
C If the	plan is a collectively-ba	argained plan, check here			
D Check	box if filing under:	Form 5558	automatic exten	sion	the DFVC program
		special extension (enter descript	ion)		_
Part II	Basic Plan Info	ormation—enter all requested inform	ation		
1a Nam SEA	e of plan	EALTH BOARD MEDICAL, DE		O & DISABILITY	<b>1b</b> Three-digit plan number (PN) ▶ 501
INS	SURANCE PLAN				<b>1c</b> Effective date of plan 01/01/1984
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 Identificat  Number (EIN)  91–0869056			2b Employer Identification Number (EIN) 91-0869056		
SEATTLE INDIAN HEALTH BOARD  2c Plan Sponsor's tele number 206-324-9360					
PO BOX 3364 611		1 12TH AVE S.		2d Business code (see instructions) 621399	
SEATTLE WA 98114-3364 SEAT		ATTLE	WA 98144		
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.					
		other penalties set forth in the instruction s well as the electronic version of this re			
SIGN (	Dully	<b>~</b>	7/24/19	PAMELA GRINDLEY	
HERE Signature of plan administrator		Date	Enter name of individual	signing as plan administrator	
SIGN HERE					
TILINE	Signature of employ	yer/plan sponsor	Date	Enter name of individual	signing as employer or plan sponsor
SIGN HERE				ř	
	Signature of DFE		Date	Enter name of individual	
For Pap	erwork Reduction Ac	For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Form 5500 (2018)			

Form 5500 (2018) v. 171027

Form 5500 (2018) Page **2** 

3a	Plan administrator's name and address 🗵 Same as Plan Sponsor			<b>3b</b> Administrator's EIN	
				3c Adminis number	trator's telephone
4	If the name and/or EIN of the plan sponsor or the plan name has changed si	ince the last ret	urn/report filed for this plan	4b EIN	
-	enter the plan sponsor's name, EIN, the plan name and the plan number from				
a c	Sponsor's name Plan Name			4d PN	
5	Total number of participants at the beginning of the plan year			5	163
6	Number of participants as of the end of the plan year unless otherwise states <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).	d (welfare plans	s complete only lines 6a(1),		
a(	1) Total number of active participants at the beginning of the plan year			6a(1)	161
a(	2) Total number of active participants at the end of the plan year			6a(2)	190
b	Retired or separated participants receiving benefits			. 6b	1
С	Other retired or separated participants entitled to future benefits			. 6c	0
d	Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b>			. 6d	191
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 witless than 100% vested			. 6h	
7	Enter the total number of employers obligated to contribute to the plan (only	multiemployer	plans complete this item)	. 7	
	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be a $4B$ $4B$ $4D$ $4E$ $4H$ $4L$ $4Q$ Plan funding arrangement (check all that apply)	des from the Lis		s in the instru	
Ju	(1) X Insurance	(1)	X Insurance	a. appiy)	
	Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3)	insurance cor	ntracts
	(3) Trust	(3)	Trust	nonos:	
10	(4) X General assets of the sponsor  Check all applicable boxes in 10a and 10b to indicate which schedules are a	(4)	X General assets of the s		(See instructions)
	•			bei attached.	(See manuchons)
а	Pension Schedules  (4)		I Schedules	matian)	
	(1) R (Retirement Plan Information)	(1)	H (Financial Inform	,	I Dlan)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Inform		ı rıan)
	Purchase Plan Actuarial Information) - signed by the plan	(3)	X 6 A (Insurance Infor	,	
	actuary 	(4)	C (Service Provide		•
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	D (DFE/Participati	•	•
	Information) - signed by the plan actuary	(6)	G (Financial Trans	saction Sched	lules)

Form 5500 (2018) Page **3** 

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)				
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)				
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.)				
11c Enter the Receipt Confirmation Code for the 2018 Form M-1 annual report. If the plan was not required to file the 2018 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				