## 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 instruc	tions to the Form 55	500.		
Pensio	on Benefit Guaranty Corporation	1			This Form is Open to Pub Inspection	olic
Part I	Annual Report	Identification Information				
For caler		fiscal plan year beginning 01/01/2018		and ending 12/31/20	)18	
A This	return/report is for:	a multiemployer plan  X a single-employer plan		• •	his box must attach a list of dance with the form instructions	s.)
		브 * ' ' '		· <del></del>		
<b>B</b> This	return/report is:	the first return/report	the final return	/report		
		an amended return/report	a short plan ye	ear return/report (less than 12	2 months)	
C If the	plan is a collectively-ba	ırgained plan, check here				
<b>D</b> Chec	k box if filing under:	Form 5558	automatic exter	nsion	the DFVC program	
	· ·	special extension (enter description	n)			
Part II	Basic Plan Info	<b>prmation</b> —enter all requested informati	<u>′</u>			
_	ne of plan	enter an requested informati	011		<b>1b</b> Three-digit plan	
	NDER INVESTMENTS.	INC.			number (PN) ▶	501
	,				1c Effective date of plan 03/01/2009	n
Mail City	ing address (include roo or town, state or provin	oyer, if for a single-employer plan) om, apt., suite no. and street, or P.O. Box) ce, country, and ZIP or foreign postal cod		ructions)	<b>2b</b> Employer Identificati Number (EIN) 91-1746890	on
HOLLAN	DER INVESTMENTS, I	NC.			2c Plan Sponsor's telep number 360-647-1916	hone
	OMMERCIAL STREET HAM, WA 98225		DMMERCIAL ST., SU HAM, WA 98225	IITE 165	2d Business code (see instructions) 525100	
Caution	· A penalty for the late	or incomplete filing of this return/repo	ort will be assessed	unless reasonable cause is	s established	
Under pe	enalties of perjury and o	other penalties set forth in the instructions, well as the electronic version of this return	I declare that I have	examined this return/report,	including accompanying sched	
SIGN			00/10/10			
HERE	Filed with authorized/v	alid electronic signature.	06/12/2019	JASON KOONI		
	Signature of plan ad	ministrator	Date	Enter name of individual s	igning as plan administrator	
SIGN HERE						
HERE	Signature of employ	er/plan sponsor	Date	Enter name of individual si	igning as employer or plan spo	nsor
SIGN						

Date

**HERE** 

Signature of DFE

Enter name of individual signing as DFE

Page 2 Form 5500 (2018) **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 a Sponsor's name c Plan Name

5	Total number of participants at the beginning of the plan year				5	428
6	Number of participants as of the end of the plan year unless otherwise stated <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).	d (welfare p	lans com	plete only lines 6a(1),		
a(	1) Total number of active participants at the beginning of the plan year				. 6a(1)	
a(	2) Total number of active participants at the end of the plan year				6a(2)	510
b	Retired or separated participants receiving benefits				. 6b	
С	Other retired or separated participants entitled to future benefits				. 6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c.				. 6d	510
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benef	its		. 6e	
f	Total. Add lines 6d and 6e.				. <b>6f</b>	
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 witl	h accrued b	enefits th	nat were		
7	less than 100% vested				_	
	If the plan provides pension benefits, enter the applicable pension feature could be pension feature feature could be pension feature feature could be pension feature feature could be pension for the pension feature feature could be pension feature feature feature could be pension feature fea					
9a	Plan funding arrangement (check all that apply)	<b>9b</b> Plan	benefit a	arrangement (check all th	at apply)	
	(1) X Insurance	(1)	X	Insurance		
	Code section 412(e)(3) insurance contracts	(2)	Ш	Code section 412(e)(3)	insuranc	e contracts
	(3) Trust	(3)	Ц	Trust		
40	(4) General assets of the sponsor	(4)	L	General assets of the s	•	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	ittached, an	d, where	indicated, enter the num	ber attach	ned. (See instructions)
а	Pension Schedules	b Gen	eral <u>S</u> ch	edules		
	(1) R (Retirement Plan Information)	(1)	Ц	H (Financial Infor	mation)	
	(a) ND (Multi-graphs on Defined Denefit Display and Cortain Manage	(2)		I (Financial Information)	mation – S	Small Plan)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3)	X	6 A (Insurance Info	rmation)	
	actuary	(4)	Ī	C (Service Provid	ler Inform	ation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	П	<b>D</b> (DFE/Participat	ing Plan I	Information)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(6)		G (Financial Tran	_	

Page 3

Form 5500 (2018)

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

on a separate So  1 Coverage Information:  (a) Name of insurance carrier  KAISER FOUNDATION HEALTH  (b) EIN  91-1467158  4708  2 Insurance fee and commission descending order of the amount  (a) Total amount  3 Persons receiving commission (a)	ny corporation	Insurance companies a pursuant to E	re required to provide the RISA section 103(a)(2).		tion	This Form is Open to Public Inspection		
For calendar plan year	r 2018 or fiscal pla	an year beginning 01/01/2018	<u> </u>	and er	nding 12/31	/2018	1	
	TMENTS, INC.				e-digit number (PN)	) <b>&gt;</b>	501	
		ne 2a of Form 5500			oyer Identifica 1746890	tion Number	(EIN)	
on a se	eparate Schedule	erning Insurance Contract A. Individual contracts grouped as						
1 Coverage Informati	on:							
` '		OF WASHINGTON OPTIONS, INC			ı	Dalianas		
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered at policy or contract	end of	(f) i	From	(g) To	
91-1467158	47055	6306700	40	•	01/01/2018		12/31/2018	
		nation. Enter the total fees and tota	al commissions paid. Lis	st in line 3	the agents, b	rokers, and	other persons in	
				<b>(b)</b> To	otal amount o	f fees paid		
		4204		. ,			0	
3 Persons receiving	commissions and	fees. (Complete as many entries	as needed to report all p	persons).				
	(a) Name	and address of the agent, broker,	or other person to whon	n commiss	sions or fees v	vere paid		
FORTIPHI LLC		P.O. BC MOUNT	OX 1547 VERNON, WA 98273					
(h) Amount of sale	es and hase	Fee	s and other commission	s paid				
commissions		(c) Amount		d) Purpos	е		(e) Organization code	
	4204						3	
	(a) Name	and address of the agent, broker,	or other person to whon	n commiss	sions or fees v	vere paid		
	· ·	•				·		
(b) Amount of sale	s and base	Fee	s and other commission	s paid				
commissions		(c) Amount	(	d) Purpos	е		(e) Organization code	

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1				
(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  (c) Amount  (d) Purpose  (e) Amount  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Amount  (e) Amount  (f) Amount of sales and base commissions paid  (g) Amount of sales and base commissions paid  (h) Amount of sales and base commissions paid						
		From and other constitutions and	(-)			
			(e) Organization			
commissions paid	(C) Amount	(a) 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		·	(e) Organization			
	(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)			
	(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)			
			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				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carri	er may be treated as a unit	for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
6		tracts With Allocated Funds:			
	а	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	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	П	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts	)	
	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	
	C	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)		
		(C)Tatal additions		70(6)	0
	٨	(6)Total additions		— <u> </u>	
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	C		7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	76(4)		
		7			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

P	art III	Welfare Benefit Contract Informa										
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ting pu	urpos	es if such	contr	acts are	expe	erience-rated as a unit	. Where c	ontrac	ts cover individual
8	Benefi	t and contract type (check all applicable boxes)										
	a X	Health (other than dental or vision)	b	Der	ntal			С	Vision		d	Life insurance
	e 🗍	Temporary disability (accident and sickness)	f 🗌	Lon	g-term dis	sability	y	g $\overline{\square}$	Supplemental unemp	oloyment	hX	Prescription drug
	. =	Stop loss (large deductible)	iΠ		O contrac				PPO contract	•	ıĦ	Indemnity contract
		Other (specify)	, <sub>□</sub>	]	o contido	•		🔼	11 0 contract		•□	machinity contract
	m 📗	Other (specify)										
9	Evnerie	ence-rated contracts:										
3	•	emiums: (1) Amount received				Г	9a(1)	Т				
		) Increase (decrease) in amount due but unpaid				-	9a(2)					
	,	) Increase (decrease) in unearned premium res				-	9a(3)					
		) Earned ( <b>(1) + (2) - (3)</b> )				_				9a(4)		
	<b>b</b> B	enefit charges (1) Claims paid					9b(1)					
	(2	) Increase (decrease) in claim reserves					9b(2)					
	(3	) Incurred claims (add <b>(1)</b> and <b>(2)</b> )								9b(3)		
	(4	) Claims charged								9b(4)		
	<b>C</b> R	emainder of premium: (1) Retention charges (c	n an a	accru	al basis) -							
		(A) Commissions					9c(1)(/					
		(B) Administrative service or other fees				F	9c(1)(E					
		(C) Other specific acquisition costs					9c(1)(0 9c(1)(0	_				
		(D) Other expenses				-	9c(1)(E					
		(E) Taxes(F) Charges for risks or other contingencies				-	9c(1)(F	_				
		(G) Other retention charges				-	<b>a</b> (4)(4					
		(H) Total retention				L				9c(1)(H	)	
	(2	2) Dividends or retroactive rate refunds. (These			_			_				
		tatus of policyholder reserves at end of year: (1			1			_		9d(1)		
		2) Claim reserves	•		•					9d(2)		
	(3	B) Other reserves								9d(3)		
	<b>e</b> D	ividends or retroactive rate refunds due. (Do n	ot incl	ude a	amount en	tered	in line 9	c(2).	)	9e		
10	None	experience-rated contracts:								_		
	<b>a</b> T	otal premiums or subscription charges paid to o	carrier							10a		213304
	re	the carrier, service, or other organization incurretention of the contract or policy, other than reply nature of costs.		, ,					•	10b		
	Specif	y nature of costs.										
	art IV	Provision of Information		na==		owe -1:	oto Cala	d! -	A2	Vas	X N	
		ne insurance company fail to provide any inform				omple	ete Sche	aule	A?	Yes	X N	U
12	If the	answer to line 11 is "Yes," specify the informat	ion no	t prov	vided.							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## **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

on a separate Sch  1 Coverage Information:  (a) Name of insurance carrier KAISER FOUNDATION HEALTH  (b) EIN  (c)  cc  91-1467158  47055  2 Insurance fee and commission descending order of the amount  (a) Total amount  3 Persons receiving commission  (a) I  FORTIPHI LLC	rporation	Insurance companies pursuant to	This For	m is Open to Public Inspection				
For calendar	plan year 20	18 or fiscal pl	an year beginning 01/01/2018		and er	nding 12/3	31/2018	•
		NTS, INC.				ee-digit n number (P	N) •	501
			ine 2a of Form 5500		-	oyer Identific -1746890	cation Number	(EIN)
Part I			erning Insurance Contrac  A. Individual contracts grouped a					
1 Coverage	Information:							
` '			OF WASHINGTON OPTIONS, IN		umbor of	ı	Policy or o	optract year
(b) EIN (c) NAIC code			(d) Contract or identification number	(e) Approximate no persons covered a policy or contract	t end of	(f)	From	ontract year (g) To
91-1467158 47055			6306600	182	•	01/01/201	8	12/31/2018
				tal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
	(a) Total a	amount of cor	mmissions paid		<b>(b)</b> T	otal amount	of fees paid	
			19845					0
3 Persons re	eceiving com	missions and	fees. (Complete as many entries	s as needed to report all	persons).			
		(a) Name	and address of the agent, broker	, or other person to who	m commiss	sions or fees	were paid	
FORTIPHI LL	С			OX 1547 IT VERNON, WA 98273				
(b) Amou	nt of sales ar	nd base	Fe	es and other commissio	ns paid			
			(c) Amount		(d) Purpos	e		(e) Organization code
		19845						3
		(a) Name	and address of the agent, broker	, or other person to who	m commiss	sions or fees	were paid	
<b>(b)</b> Amou	nt of sales ar	nd base	Fe	es and other commissio	ns paid			
For calendar plan year  A Name of plan HOLLANDER INVEST  C Plan sponsor's nam HOLLANDER INVEST  Part I Inform on a sep 1 Coverage Information (a) Name of insurance KAISER FOUNDATION  (b) EIN  91-1467158  2 Insurance fee and condescending order of (a) Total  3 Persons receiving conformation  FORTIPHI LLC  (b) Amount of sales commissions			(c) Amount		(d) Purpos		(e) Organization code	
For Panerus	ork Reductio	n Act Notice	see the Instructions for Form	5500			School	dule A (Form 5500) 2018

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1				
(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  (c) Amount  (d) Purpose  (e) Amount  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Amount  (e) Amount  (f) Amount of sales and base commissions paid  (g) Amount of sales and base commissions paid  (h) Amount of sales and base commissions paid						
		From and other constitutions and	(-)			
			(e) Organization			
commissions paid	(C) Amount	(a) 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		·	(e) Organization			
	(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)			
	(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)			
			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				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carri	er may be treated as a unit	for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
6		tracts With Allocated Funds:			
	а	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	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	П	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts	)	
	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	
	C	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)		
		(C)Tatal additions		70(6)	0
	٨	(6)Total additions		— <u> </u>	
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	C		7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	76(4)		
		7			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

P	art I	II	Welfare Benefit Contract Information if more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group	p of e	ses if	such co	ntracts are	e exp	erience-rated as a ι	ınit. Where d	contract	ts cover individual
8	Bene	efit a	and contract type (check all applicable boxes)										
	a	Не	ealth (other than dental or vision)	b	Dε	ental			С	Vision		d	Life insurance
	е	Τe	emporary disability (accident and sickness)	f □	∃ Lo	ong-ter	rm disab	ility	g	Supplemental une	employment	h X	Prescription drug
	ιĖ	_	op loss (large deductible)	ιĖ	_	MO cor		,		PPO contract	' '	- =	Indemnity contract
	L	_		, _	٦	VIO 001	THIOU			11 0 contract		•П	macminity contract
	m [		ther (specify)										
a	Evne	rion	ce-rated contracts:										
•			niums: (1) Amount received					9a(′	1)				
			ncrease (decrease) in amount due but unpaid						-				
			ncrease (decrease) in unearned premium res						-				
		` '	Earned ((1) + (2) - (3))								9a(4)		
		. ,	nefit charges (1) Claims paid								, , ,		
		(2) lı	ncrease (decrease) in claim reserves					9b(2	2)				
		(3) lı	ncurred claims (add (1) and (2))								9b(3)		
		(4) C	Claims charged								9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	n an	accr	rual ba	ısis)						
			(A) Commissions										
			(B) Administrative service or other fees					0 (4)					
			(C) Other specific acquisition costs					0.74					
			(D) Other expenses					0-/4)					
			(E) Taxes										
			(F) Charges for risks or other contingencies.					90(1)	(G)				
			(G) Other retention charges(H) Total retention								9c(1)(H	ı\	
			Dividends or retroactive rate refunds. (These				_		_			'	
	d		tus of policyholder reserves at end of year: (1										
	u		Claim reserves										
		` '	Other reserves										
	е	` '	dends or retroactive rate refunds due. (Do n										
10			perience-rated contracts:						( )	,			
			al premiums or subscription charges paid to o	carrie	r						10a		660573
	_	rete	e carrier, service, or other organization incur- ention of the contract or policy, other than rep- nature of costs.								10b		
		cify r	nature of costs.	onted		art i, iii		ove, repor	· ame				
Р	art I	V	Provision of Information										
11	Dic	the	insurance company fail to provide any inform	nation	n nec	essary	y to com	plete Sch	edule	A?	Yes	X N	0
			nswer to line 11 is "Yes," specify the informat									<u></u>	

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 El	RISA section 103(a)(2)			111101011	Inspection
For calendar plan year 20	18 or fiscal plar	n year beginning 01/01/2018		and en	ding 12/3	1/2018	
A Name of plan HOLLANDER INVESTME	ENTS, INC.			B Three-digit plan number (PN)			501
C Plan sponsor's name a HOLLANDER INVESTME		e 2a of Form 5500			yer Identific 1746890	ation Number (	EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE		OF THE NORTHWEST					
(1.) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To
93-0798039	95540	16116	66		01/01/2018	8	12/31/2018
		ation. Enter the total fees and tota	l commissions paid. Li	st in line 3	the agents,	brokers, and of	her persons in
(a) Total a	amount of comr	otal amount	of fees paid				
		7557					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker, o		n commiss	ions or fees	were paid	
FORTIPHI LLC		P.O. BO MOUNT	X 1547 VERNON, WA 98273				
(b) Amount of sales ar	nd base	Fees	and other commission	ns paid			
` '		(c) Amount	(d) Purpose				(e) Organization code
	7557						3
	(a) Name a	nd address of the agent, broker, o	or other person to whor	n commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fees	and other commission	ns paid			
` '		(c) Amount		(d) Purpose	9		(e) Organization code
2 Insurance fee and commission in descending order of the amount of a) Total amount of a Persons receiving commissions  (a) N  FORTIPHI LLC  (b) Amount of sales and base commissions paid							

Schedule A (Form 5500	) 2018	Page <b>2 –</b> 1				
(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  (c) Amount  (d) Purpose  (e) Amount  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Amount  (e) Amount  (f) Amount of sales and base commissions paid  (g) Amount of sales and base commissions paid  (h) Amount of sales and base commissions paid						
		From and other constitutions and	(-)			
			(e) Organization			
commissions paid	(C) Amount	(a) 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		·	(e) Organization			
	(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)			
	(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)			
			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				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carri	er may be treated as a unit	for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
6		tracts With Allocated Funds:			
	а	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	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	П	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts	)	
	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	
	C	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)		
		(C)Tatal additions		70(6)	0
	٨	(6)Total additions		— <u> </u>	
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	C		7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	76(4)		
		7			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

P	art I	II	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual.	group	of e	ses if suc	ch cont	racts are	expe	erience-rated as a uni	t. Where c	ontract	ts cover individual	
8	Bene	fit a	nd contract type (check all applicable boxes)											
	a	Не	ealth (other than dental or vision)	b	De	ental			С	Vision		d	Life insurance	
	еĒ	Τe	emporary disability (accident and sickness)	f	Lo	ng-term	disabili	tv	g∏	Supplemental unem	ployment	h 🔀	Prescription drug	
	ιĖ	-	op loss (large deductible)	iX	_	//O contra		-	- 느	PPO contract	, ,	- =	Indemnity contract	
	<u> </u>	_		, <u>\</u>	<u> </u>	no contro	uot		., □	1110 continuot		• ш	macrimity contract	
	m _		ther (specify)											
a	Evne	rion	ce-rated contracts:											-
5	•		iums: (1) Amount received					9a(1)						
			ncrease (decrease) in amount due but unpaid											
			ncrease (decrease) in unearned premium res						_					
		` '	Earned ((1) + (2) - (3))								. 9a(4)			_
		. ,	efit charges (1) Claims paid											
	(	(2) lı	ncrease (decrease) in claim reserves					9b(2)	)					
		(3) lı	ncurred claims (add (1) and (2))								. 9b(3)			
	(	(4) (	Claims charged								. 9b(4)			
	С	Ren	nainder of premium: (1) Retention charges (c	n an	accru	ual basis	i)							
			(A) Commissions						_					
			(B) Administrative service or other fees					0 /4\//						
			(C) Other specific acquisition costs					0 /4 \ / !						
			(D) Other expenses					0 - /4 \ / [	_					
			(E) Taxes											
			(F) Charges for risks or other contingencies (G) Other retention charges				• • • • • • • • • • • • • • • • • • • •	9c(1)(	3)					
			(H) Total retention(H)								9c(1)(H	)		-
			Dividends or retroactive rate refunds. (These			_			_					_
			us of policyholder reserves at end of year: (1											-
	u		Claim reserves								9d(2)			_
		` '	Other reserves											_
		` '	dends or retroactive rate refunds due. (Do n											
10			erience-rated contracts:							,				
	а	Tota	al premiums or subscription charges paid to o	arrier	r						. 10a		34350	)6
	_	rete	e carrier, service, or other organization incurrention of the contract or policy, other than repeature of costs.								. 10b			
P	_	rete	ntion of the contract or policy, other than rep								. 10b			
			insurance company fail to provide any inform	nation	nec	essarv to	COMP	lete Sche	dule	А? П	Yes	X N	0	
								iete Sche	uule	A!	169	^ IN	<u> </u>	_
12	If th	ie ar	nswer to line 11 is "Yes," specify the informat	ion no	ot pro	ovided.	•							

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

r dision belief to duranty of	Siporation	Insurance companies ar pursuant to El		This Form is Open to Public Inspection				
For calendar plan year 20	18 or fiscal pla	an year beginning 01/01/2018		and er	nding 12/31	/2018		
A Name of plan HOLLANDER INVESTMI	ENTS, INC.				ee-digit n number (PN	) •	501	
C Plan sponsor's name a		ne 2a of Form 5500	D Employer Identification Number (EIN) 91-1746890					
on a separ		rning Insurance Contract A. Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca		DMPANY			1	Dation		
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered at policy or contract	end of	(f)	From	ontract year (g) To	
13-5581829	65978	KMO5989370	510	year	01/01/2018		12/31/2018	
2 Insurance fee and com descending order of the		nation. Enter the total fees and tota	I commissions paid. Lis	st in line 3	the agents, b	orokers, and	other persons in	
(a) Total								
(a) Total amount of commissions paid (b) Total amount of fees paid  5825 13								
3 Persons receiving com	missions and	fees. (Complete as many entries a	as needed to report all p	persons).				
	(a) Name	and address of the agent, broker, o	or other person to whom	n commiss	sions or fees v	were paid		
FORTIPHI LLC		P.O. BO MOUNT	X 1547 VERNON, WA 98273					
(b) Amount of sales a	nd hase	Fees	s and other commission	s paid				
commissions pa		(c) Amount	(	d) Purpos	e		(e) Organization code	
	5825	13					3	
	(a) Name	and address of the agent, broker, o	or other person to whom	n commiss	sions or fees v	were paid		
(b) Amount of sales and base Fees and other commissions paid								
commissions pa		(c) Amount	(	d) Purpos	e		(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) 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				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carri	er may be treated as a unit	for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
6		tracts With Allocated Funds:			
	а	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	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	П	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts	)	
	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	
	C	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)		
		(C)Tatal additions		70(6)	0
	٨	(6)Total additions		— <u> </u>	
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	C		7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	76(4)		
		7			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

P	art	II	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individuals.	group of employees of the	tracts are expe	erience-rated as a unit	. Where co	ontracts cover individual	
8	Ben	efit a	nd contract type (check all applicable boxes)						
	а	Не	ealth (other than dental or vision)	<b>b</b> X Dental	С	Vision		<b>d</b> X Life insurance	
	е	_	emporary disability (accident and sickness)	f Long-term disabili	ity <b>g</b>	Supplemental unemp	olovment	h Prescription drug	
	i	_		j HMO contract	· - <u>-</u>	PPO contract	,	- =	
	L	_	op loss (large deductible)	I HIVIO CONTIACT	k_	PPO COMITACI		I Indemnity contract	
	m	O	ther (specify) ▶AD&D						
<u> </u>			united contracts.						
9			ce-rated contracts:		00(4)			_	
	a i		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				σα( .)		
			ncrease (decrease) in claim reserves					_	
			ncurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		
			Claims charged				9b(4)		
	C	Ren	nainder of premium: (1) Retention charges (c	on an accrual basis)					
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees						
			(C) Other specific acquisition costs						
			(D) Other expenses						
			(E) Taxes					_	
			(F) Charges for risks or other contingencies.		0-(4)(0)			_	
			(G) Other retention charges				00/41/11	<u> </u>	
			(H) Total retention	_	_		9c(1)(H)	<del>,   </del>	
	اہ		Dividends or retroactive rate refunds. (These		L-1				
	d		tus of policyholder reserves at end of year: (1						
		` '	Claim reserves				9d(2) 9d(3)		
	е	` '	Other reservesdends or retroactive rate refunds due. (Do n						
10			perience-rated contracts:	of morade amount enteres	a iii iiiic <b>30(2)</b> .	<i>j</i>	JC		
. •	a		al premiums or subscription charges paid to o	carrier			10a	172	816
	b	If th	e carrier, service, or other organization incur- ntion of the contract or policy, other than rep	red any specific costs in c	connection with	h the acquisition or	10b	112	
	b Spe	If the rete cify r	e carrier, service, or other organization incurnition of the contract or policy, other than rephature of costs.  Provision of Information	red any specific costs in corted in Part I, line 2 above	connection with	h the acquisition or unt	10b		
11	Dic	the	insurance company fail to provide any inform	nation necessary to comp	lete Schedule	А?	Yes	X No	
			nswer to line 11 is "Yes," specify the informat		.c.c Goriodule	···	- <del>-</del>	<u></u>	

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

	Inspection								
For calendar plan year	2018 or fiscal plar	n year beginning 01/01/2018	and er	nding 12/31/2018	_				
A Name of plan HOLLANDER INVEST	MENTS, INC.			e-digit number (PN)	501				
C Plan sponsor's nam HOLLANDER INVEST		e 2a of Form 5500		oyer Identification Number 1746890	(EIN)				
		rning Insurance Contract ( Individual contracts grouped as							
1 Coverage Information	on:								
(a) Name of insurance KAISER FOUNDATION		DF WASHINGTON							
41 EN	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or o	ontract year				
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To				
91-0511770	95672	1414600	6	01/01/2018	12/31/2018				
2 Insurance fee and c descending order of		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers, and	other persons in				
(a) Total amount of commissions paid (b) Total amount of fees paid									
	685 0								
3 Persons receiving c	ommissions and fe	ees. (Complete as many entries a	s needed to report all persons).						
	(a) Name a	and address of the agent, broker, c	or other person to whom commiss	ions or fees were paid					
FORTIPHI LLC		P.O. BO MOUNT	X 1547 VERNON, WA 98273						
(b) Amount of sales	s and base	Fees	and other commissions paid						
commissions	paid	(c) Amount	(d) Purpos	е	(e) Organization code				
	685			3					
	(a) Name a	and address of the agent, broker, c	or other person to whom commiss	sions or fees were paid					
		•							
(b) Amount of sales	s and base	Fees	and other commissions paid						
commissions		(c) Amount	(d) Purpos	e	(e) Organization code				
For Donomyouk Dodge	diam Ant Nati	and the Instructions for Form 55			dula A (Farra FF00) 2040				

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				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carri	er may be treated as a unit	for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in separate accounts at year er			
6		tracts With Allocated Funds:			
	а	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	I annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	П	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts	)	
	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	
	C	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)		
		(C)Tatal additions		70(6)	0
	٨	(6)Total additions		— <u> </u>	
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	C		7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	76(4)		
		7			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

P	art I	II	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual.	group ting p	of e	ses if s	such con	tracts are	expe	erience-rated as a un	it. Where c	ontract	ts cover individual
8	Bene	efit a	nd contract type (check all applicable boxes)										
	a	Не	ealth (other than dental or vision)	b	De	ental			С	Vision		d	Life insurance
	еĒ	Τe	emporary disability (accident and sickness)	f ┌	Lo	ong-tern	n disabi	lity	gΠ	Supplemental unem	ployment	h 🔀	Prescription drug
	ιĖ	_	op loss (large deductible)	ιĖ		MO con		,		PPO contract	. ,	- =	Indemnity contract
	<u>_</u>	_		, _	」''''	VIO 0011	itiaot			110 contract		• Ш	macming contract
	m [		ther (specify)										
a	Evno	rion	ce-rated contracts:										
•	•		niums: (1) Amount received					. 9a(1	)				
			ncrease (decrease) in amount due but unpaid					•	_				
			ncrease (decrease) in unearned premium res						-				
		` '	Earned ((1) + (2) - (3))								9a(4)		
		. ,	efit charges (1) Claims paid								, ,		
		(2) lı	ncrease (decrease) in claim reserves					. 9b(2	)				
		(3) lı	ncurred claims (add (1) and (2))								9b(3)		
		(4) C	Claims charged								9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	n an	accr	ual bas	sis)						
			(A) Commissions						_				
			(B) Administrative service or other fees					0 (4)/					
			(C) Other specific acquisition costs					0.7417					
			(D) Other expenses					0-/41/					
			(E) Taxes										
			(F) Charges for risks or other contingencies.					90(1)(	G)				
			(G) Other retention charges(H) Total retention								9c(1)(H	n	
			Dividends or retroactive rate refunds. (These			_	_		_			'	
	d		tus of policyholder reserves at end of year: (1			<u></u>			ш				
	u		Claim reserves										
		` '	Other reserves										
	е	` '	dends or retroactive rate refunds due. (Do n										
10			perience-rated contracts:						- ( /	,			
			al premiums or subscription charges paid to o	carrier	r						10a		30533
	b	If th	e carrier, service, or other organization incur ntion of the contract or policy, other than rep nature of costs.	red ar	ny sp	oecific c	costs in	connectio	n with	h the acquisition or			
		cify r	nature of costs.	orted	IN Pa	art I, Iin	e 2 abo	ve, report	amo	unt	106		
P	art l	V	Provision of Information								1		
11	Did	the	insurance company fail to provide any inform	nation	nec	essary	to comp	olete Sche	edule	A?	Yes	X N	0
12	If th	ne ar	nswer to line 11 is "Yes," specify the informat	ion no	ot pro	ovided.	•						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

Insurance companies are required to provide the information

OMB No. 1210-0110

			RISA section 103(a)(2).	Inis For	m is Open to Public Inspection			
For calendar plan year 20	18 or fiscal plan	year beginning 01/01/2018	and en	ding 12/31/2018				
A Name of plan HOLLANDER INVESTME	ENTS, INC.			e-digit number (PN)	501			
C Plan sponsor's name a HOLLANDER INVESTME		e 2a of Form 5500	·	yer Identification Number (1746890	(EIN)			
		ning Insurance Contract ( . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca COLONIAL LIFE & ACCID		CE COMPANY						
/L) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or co	ontract year			
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To			
57-0144607	62049	E4098984	29	01/01/2018	12/31/2018			
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers, and o	ther persons in			
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid							
4503 2009								
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all persons).					
	(a) Name a	nd address of the agent, broker, o		ions or fees were paid				
RYAN G YOUNG		5845 FM BEN WH	l 314 IEELER, TX 75754					
(b) Amount of sales ar	nd base	Fees	and other commissions paid					
commissions pai	id	(c) Amount	(d) Purpose	e e e e e e e e e e e e e e e e e e e	(e) Organization code			
	1795	1821						
	(a) Name a	nd address of the agent, broker, c	or other person to whom commiss	ions or fees were paid				
FORTIPHI LLC	(5)	P.O. BO						
(b) Amount of color or	nd hasa	Fees	and other commissions paid					
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purpose	<del></del>	(e) Organization code			
·	1515				3			
For Panerwork Peductio	n Act Notice s	see the Instructions for Form 55	500	School	dule A (Form 5500) 2018			

Schedule A (Form 5500)	2018	Page <b>2 –</b> 1	
(a) Nar	1313 I	r, or other person to whom commissions or fees were paid E MAPLE STREET INGHAM, WA 98225	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
586			3
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
PAMELA COPLE SMITH		IIGHLAND DRIVE TLE, WA 98109	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
153	15		3
422			
		r, or other person to whom commissions or fees were paid  LAKE CITY WAY NE	
		TLE, WA 98125	
(In) Amount of colors and have		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
112	29		3
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
BENEFITS BY DESIGN INC		NE 279TH STREET EFIELD, WA 98642	
40.0		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
91	45		3
(a) Nan	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
BRIAN T MURPHY LLC	5002 4	47TH AVE SW TLE, WA 98136	
(h) Amount of color and ha		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

Page	2	_	2

<b>(a)</b> Nan	ne and address of the agent, broker,	or other person to whom commissions or fees were paid	
MARK CHARLES MORGAN		WILLAMETTE DRIVE NE	
	LACE	Y, WA 98516	
			(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
35	30		3
(a) Nan	ne and address of the agent, broker.	or other person to whom commissions or fees were paid	
TAI D SHIN		POPPY LANE SW	
		VATER, WA 98512	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization code
commissions paid	28	(*)	3
.,	20		
			•
		or other person to whom commissions or fees were paid	
ROXANA BUSCHMAN		ORTHEAST 149TH STREET OUVER, WA 98685	
		,	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
29			3
<b>(a)</b> Nan	ne and address of the agent, broker,	or other person to whom commissions or fees were paid	
PREMIER WORKSITE SOLUTIONS	INC 112 N	W 114TH STREET	
	VANC	OUVER, WA 98685	
			T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
. 12	16		3
(a) Nan	ne and address of the agent broker	or other person to whom commissions or fees were paid	
CHRISTOPHER ROBERT BERRY		75TH AVE WEST	
OTIMOTOT TIER ROBERT BERRY	LYNN'	WOOD, WA 98036	
	1	Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(w) i dipose	code

9

JODI MOYLAN

Page	2 –	3

	PUYA	LLUP, WA 98375	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
18			3
(a) Nan	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	·
ROBERT MORRISON	937 T	HIMBLEBERRY DRIVE LE ROCK, WA 98611	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
12	1		3
		, or other person to whom commissions or fees were paid	
HEATHER THURMIN RICHINS		NE 114TH PL AND, WA 98033	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
8	4		
(a) Nan	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	,
DEANA SCHROEDER		120TH AVE SE , WA 98031	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
4	7		
(a) Nan	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
CHRISTINE LYNN MORGESTER	988 S TROU	W 26TH STREET ITDALE, OR 97060	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
9			3
			<u> </u>

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

19103 MERIDIAN EAST

Page	2 –	4

		r, or other person to whom commissions or fees were paid	_
GABRIEL ANGEL CANALS		NE 236TH AVE D VILLAGE, OR 97060	
		of vice (or, or, or, or, or, or, or, or, or, or,	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
8			3
(a) Nam	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
MEGAN ELIZABETH CASTRO		CARNEY DRIVE SE	
	OLYN	MPIA, WA 98501	
(b) Amount of color and have		Fees and other commissions paid	(e) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	code
2	2		
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid	
DOUGLAS EDWARD VIESELMEYER		5 115TH AVE CT. E	
BOOCH O EDWARD VIEGELMETER		ILLUP, WA 98374	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
1	1		code
·	•		
(a) Now	a and address of the agent broke	ar other nersen to whom commissions or feed were neid	
BROOKS AGENCY INC		r, or other person to whom commissions or fees were paid EFFERIES STREET	
BROOKS AGENOT ING		ALE, TX 75771	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	1	(4) - 4-1-333	code 3
· ·			
			<u> </u>
		r, or other person to whom commissions or fees were paid	
JULIE WOLDEN	2231 LONG	LARCH STREET GVIEW, WA 98632	
	LONG		
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
1			3

F	Part				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with each carri	er may be treated as a unit	for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in separate accounts at year el			
6		tracts With Allocated Funds:			
	а	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	П	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts	)	
	а	Type of contract: (1) deposit administration (2) immedia	te participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		(*) 🗋 3***********************************			
	b	Balance at the end of the previous year		7b	
	C	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)		
		(C)Tatal additions		70(6)	0
	٨	(6)Total additions			
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )  Deductions:			
	C		7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. 76(4)		
		7			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

P	art III	Welfare Benefit Contract Inform				
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual to the contract of the same that the contract covers the same the information of the same that the contract covers the same that the contract covers the same the contract covers the same that the contract covers the contract covers the contract covers the covers	ting purposes if such conf	tracts are expe	erience-rated as a unit. Where	contracts cover individual
8	Benefit	and contract type (check all applicable boxes)				
	a ∏ ⊦	Health (other than dental or vision)	<b>b</b> Dental	С	Vision	<b>d</b> X Life insurance
		Temporary disability (accident and sickness)	f X Long-term disabili	<u> </u>	Supplemental unemployment	h ☐ Prescription drug
		Stop loss (large deductible)	j HMO contract	· - <u>-</u>	PPO contract	I  Indemnity contract
			) [] Third contract	\_	1 1 0 contract	I I Indemnity contract
	m 📋 (	Other (specify)				
9	Funaria	non rated contracts.				
J	•	nce-rated contracts: miums: (1) Amount received		. 9a(1)		
		Increase (decrease) in amount due but unpai				
	` '	Increase (decrease) in unearned premium re				
		Earned ((1) + (2) - (3))			9a(4)	
	_ ` '	enefit charges (1) Claims paid				
		Increase (decrease) in claim reserves		21 (2)		
	(3)	Incurred claims (add (1) and (2))			9b(3)	)
	(4)	Claims charged			9b(4)	,
	C Re	emainder of premium: (1) Retention charges (	on an accrual basis)			
		(A) Commissions		9c(1)(A)		
		(B) Administrative service or other fees				
		(C) Other specific acquisition costs				
		(D) Other expenses		0-(4)(5)		
		(E) Taxes				
		(F) Charges for risks or other contingencies.		0 (4)(0)		_
		(G) Other retention charges(H) Total retention			9c(1)(H	-1)
	(2)	) Dividends or retroactive rate refunds. (These	_	_		
		ratus of policyholder reserves at end of year: (	_			
		) Claim reserves	•			
	` '	) Other reserves			2.1(2)	
	` '	vidends or retroactive rate refunds due. (Do n				
10		xperience-rated contracts:		,	,	
		otal premiums or subscription charges paid to	carrier		10a	23129
	re	the carrier, service, or other organization incur tention of the contract or policy, other than rep	, ,		•	
	re	, ,	, ,		•	
	art IV	Provision of Information	nation necessary to comp	lete Schedule	A? \(\sum \) Yes	⊠ No
		e insurance company fail to provide any inform		iele scriedule	∴ ∧: ∐ 169	<u> </u>
12	If the	answer to line 11 is "Yes," specify the informat	tion not provided.			

#### Service Provider Affidavit

I certify that I have been specifically authorized in writing by the plan administrator/employer, as applicable, to enter my EFAST2 PIN on this return/report in order to electronically submit this return/report. I further certify that: (1) I will retain a copy of the administrator's/employer's specific written authorization in my records; (2) I have attached to this electronic filing, in addition to any other required schedules or attachments, a true and correct PDF copy of the first two pages of the completed Form 5500 or Form 5500-SF return/report bearing the manual signature of the plan administrator/employer under penalty of perjury; (3) I advised the plan administrator/employer that by selecting this electronic signature option the PDF image of that manual signature will be included with the rest of the return/report posted by the Department of Labor (DOL) on the Internet for public disclosure; and (4) I will communicate to the plan administrator/employer any inquiries and information that I receive from EFAST2, DOL, IRS or PBGC regarding this annual return/report.

The Ca CO

Date

| 06/12/2019 | KEITH CARLSON | Enter name of individual si

Signature of service provider (optional)

Enter name of individual signing as service provider

### 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 Annual Report Identification Inf	ormation			
For calendar plan year 2018 or fiscal plan year begin	ning 01/01/	2018 and ending	12/31/2018	
A This return/report is for: a multiemployer pl	an aı	a multiple-employer plan (Filers checking this box must attach a list of		
_	pa	rticipating employer inforn	nation in accordance with the f	form instr.)
X a single-employer i		OFE (specify)		
B This return/report is: the first return/report	ort the	e final return/report		
an amended return	n/report as	short plan year return/repo	ort (less than 12 month <u>s)</u>	
C If the plan is a collectively-bargained plan, check here	ı, check here			
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 re	equested information			
1a Name of plan			1b Three-digit	-04
HOLLANDER INVESTMENTS, INC.			plan number (PN)	501
			1c Effective date of plan 03/01/2009	
2a Plan sponsor's name (employer, if for a single-employer pl	an)		2b Employer Identification N	lumber (EIN)
Mailing address (include room, apt., suite no. and street, or	r P.O. Box)		91-1746890	
City or town, state or province, country, and ZIP or foreign	postal code (if foreign, se			
HOLLANDER INVESTMENTS, INC.		360-647-1916		
			2d Business code (see instruction 525100	uctions)
119 N. COMMERCIAL STREET, SU	ITE 165			
BELLINGHAM WA	98225			
		a'		
Caution: A penalty for the late or incomplete filing of t	his return/report will	be assessed unless reas	sonable cause is established.	
Under penalties of perjury and other penalties set forth in the instructions, I das the electronic version of this return/report, and to the best of my knowled			anying schedules, statements and attach	nments, as well
SIGN COLOR SIGN	F/20/10			
HERE TOUCHOUT	7/29/19	JASON KOONI		
Signature of plan administrator	Date	Enter name of individual	signing as plan administrator	
SIGN				
HERE				
Signature of employer/plan sponsor	Date	Enter name of individual	signing as employer or plan sp	onsor
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 (2018) v. 171027

	Form 5500 (2018)	F	Page 2		
3a	Plan administrator's name and address X Same as Plan Sponsor		3b Administ 3c Administ		EIN telephone number
	If the name and/or EIN of the plan sponsor or the plan name has change enter the plan sponsor's name, EIN, the plan name and the plan number Sponsor's name Plan Name	•		plan,	4b EIN 4d PN
a b c d e f g h	Total number of participants at the beginning of the plan year  Number of participants as of the end of the plan year unless otherwise of 6a(1), 6a(2), 6b, 6c, and 6d).  (1) Total number of active participants at the beginning of the plan year (2) Total number of active participants at the end of the plan year Retired or separated participants receiving benefits  Other retired or separated participants entitled to future benefits  Subtotal. Add lines 6a(2), 6b, and 6c  Deceased participants whose beneficiaries are receiving or are entitled total. Add lines 6d and 6e  Number of participants with account balances as of the end of the plan complete this item)  Number of participants who terminated employment during the plan year less than 100% vested  Enter the total number of employers obligated to contribute to the plan this item)	to receive benefits  year (only defined contribute ar with accrued benefits the contribute only multiemployer plans of the contribute of t	ution plans at were	6a(1) 6a(2) 6b 6c 6d 6e 6f 6g	510
b 4A	If the plan provides pension benefits, enter the applicable pension feature.  If the plan provides welfare benefits, enter the applicable welfare feature.  4B 4D 4E 4Q  Plan funding arrangement (check all that apply)  (1)	9b Plan benefit arrange (1) X Insurance (2) Code secti	ın Characteristic	that ap	es in the instructions:
10 а	Check all applicable boxes in 10a and 10b to indicate which schedules (See instructions)  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		(Financial Inf (Financial Inf (Financial Inf (Insurance In (Service Prov (DFE/Particip	ne num formatic formatic formatic vider Interesting P	on) on - Small Plan) ion)