

Application for Determination for Employee Benefit Plan

(Under sections 401(a) and 501(a) of the Internal Revenue Code)

Department of the Treasury Internal Revenue Service

OMB No. 1545-0197 Expires 11-30-95

For IRS Use Only

File folder number Case number

File page 1 of Form 5300 in duplicate.

Note: User fee must be attached to this application. (See What To File.) Enter amount of user fee submitted

The information provided on this form will be read by computer. Therefore page 1 must be typed (except the signature). Please enter information exactly as requested and only in the space provided. Do not type in areas that are shaded.

Review the Procedural Requirements Checklist on page 4 before submitting this application.

1a Name of plan sponsor (employer if single-employer plan) 1b Employer identification number 1c Employer's tax year ends-Enter N/A or (MM) 1d Telephone number

2 Person to be contacted if more information is needed. (See instructions.) (If the same as line 1a, leave blank.) (Complete even if a Power of Attorney is attached): Name Number, street, and room or suite no. (If a P.O. box, see instructions.) City State ZIP code Telephone number

3a Determination requested for (enter applicable number(s) at left and fill in required information). (See instructions.) Enter 1 for Initial Qualification—Date plan signed Enter 2 for Amendment after initial qualification—Is plan restated? Yes No Date amendment signed Date amendment effective Enter 3 for Affiliated Service Group status (section 414(m))—Date effective Enter 4 for Leased Employee Status Enter 5 for Partial termination—Date effective b Has the plan received a determination letter? If "Yes," submit a copy of the latest letter Yes No c Have interested parties (as defined in Treasury Regulations section 1.7476-1) been given the required notification of this application? Yes No d Does the plan have a cash or deferred arrangement, or employee or matching contributions (section 401(k) or (m))? Yes No Name of Plan:

4a b Enter plan number (3 digits) c Enter date plan year ends (MMDD) d Enter date plan effective (MMDDYY) e Enter number of participants in plan

5a If this is a defined benefit plan, enter the appropriate number in box at left. Enter 1 for unit benefit Enter 2 for fixed benefit Enter 3 for flat benefit Enter 4 for other (Specify) b If this is a defined contribution plan, enter the appropriate number in box at left. Enter 1 for profit sharing Enter 2 for stock bonus Enter 3 for money purchase Enter 4 for target benefit Enter 5 for ESOP Enter 6 for other (Specify)

6a Is the employer a member of an affiliated service group? Enter 1 if "Yes" Enter 2 if "No" Enter 3 if "Not Certain" b Is the employer a member of a controlled group of corporations or a group of trades or businesses under common control? Enter 1 if "Yes" Enter 2 if "No"

7 Enter type of plan: Enter 1 if governmental plan Enter 2 if church plan not subject to ERISA (see instructions) Enter 3 if multiple employer plan (described in section 413(c)). Enter number of participating employers Enter 4 if section 412(i) plan Enter 5 if other

Under penalties of perjury, I declare that I have examined this application, including accompanying statements, and to the best of my knowledge and belief, it is true, correct, and complete. Both copies of this page must be signed.

Signature Title Date

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< _____ > Number, street, and room or suite no. (If a P.O. box, see instructions.)	< _____ >
< _____ > City State ZIP code	1c Employer's tax year ends—Enter N/A or (MM)
< _____ > < _____ > < _____ >	1d Telephone number () _____

2 Person to be contacted if more information is needed. (See instructions.) (If the same as line 1a, leave blank.) (Complete even if a Power of Attorney is attached):

Name

< _____ >
Number, street, and room or suite no. (If a P.O. box, see instructions.)

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City State ZIP code Telephone number
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Date amendment signed _____ Date amendment effective _____	_____
< _____ > Enter 3 for Affiliated Service Group status (section 414(m))—Date effective _____	_____
< _____ > Enter 4 for Leased Employee Status _____	_____
< _____ > Enter 5 for Partial termination—Date effective _____	_____

b Has the plan received a determination letter? If "Yes," submit a copy of the latest letter Yes < _____ > No < _____ >

c Have interested parties (as defined in Treasury Regulations section 1.7476-1) been given the required notification of this application? Yes < _____ > No < _____ >

d Does the plan have a cash or deferred arrangement, or employee or matching contributions (section 401(k) or (m))? Yes < _____ > No < _____ >

Name of Plan: _____

4a < _____ >

< _____ > b Enter plan number (3 digits) _____	d Enter date plan effective (MMDDYY) _____
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Enter 2 for stock bonus	Enter 5 for ESOP
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6a Is the employer a member of an affiliated service group?
< _____ > Enter 1 if "Yes" Enter 2 if "No" Enter 3 if "Not Certain"

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Enter 3 if multiple employer plan (described in section 413(c)). Enter number of participating employers _____
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Signature ▶ Title ▶ Date ▶

- 8a** Do you maintain any other qualified plan(s)? (See instructions.) **Yes** **No**
 If "No," skip to line 8c.
- b** If this is a defined contribution plan and you also maintain a defined benefit plan, or if this is a defined benefit plan and you also maintain a defined contribution plan, when the plan is top-heavy, do non-key employees covered under both plans receive:
- (1) the top-heavy minimum benefit under the defined benefit plan? **Yes** **No**
 (2) at least a 5% minimum contribution under the defined contribution plan? **Yes** **No**
 (3) the minimum benefit offset by benefits provided by the defined contribution plan? **Yes** **No**
 (4) benefits under both plans that, using a comparability analysis, are at least equal to the minimum benefit? (See instructions.) **Yes** **No**
- c** Do the provisions of the plan preclude the possibility that the section 415 limitations will be exceeded for any employee who is (or has been) a participant in this plan and any other plan of the employer? **Yes** **No**

9 COVERAGE (See instructions.):

- a** Is the employer applying the separate line of business rules of section 414(r)? **Yes** **No**
 (If "Yes," see instructions.)
- b** Does the employer receive services from any leased employees within the meaning of section 414(n)? **Yes** **No**
- c** Coverage of plan at (give date) _____
- d** Enter the percentage of nonhighly compensated employees who benefit under the plan, excluding employees who benefit only under a part of the plan containing a CODA or employee or matching contributions. (If 70% or more, skip line 9e and go to line 9f.) **N/A** _____ %
- e** Divide the percentage of nonhighly compensated employees who benefit under the plan (line 9d) by the percentage of highly compensated employees who benefit under the plan, excluding employees who only benefit under a part of the plan containing a CODA or employee or matching contributions. **N/A** _____
- f** If the plan contains a CODA, compute the ratio in line 9e above on the basis of employees eligible to make elective deferrals under the CODA portion of the plan **N/A** _____
- g** If the plan provides for employee or matching contributions, compute the ratio in line 9e above on the basis of employees eligible to make employee contributions or to receive matching contributions under the plan **N/A** _____
- h** Are the results in line 9e, 9f, or 9g based on the aggregated coverage of more than one plan? (If "Yes," see instructions.) **Yes** **No**
- i** If line 9e, 9f, or 9g is less than 70%, does the plan pass the average benefit test? **N/A** **Yes** **No**
 (1) Enter the safe harbor percentage _____
 (2) Enter the average benefit percentage. (See instructions.) _____
- j** Enter total number of employees _____

10 PERMITTED DISPARITY:

N/A	Yes	No

- a** If the plan provides for disparity in contributions or benefits, is the plan intended to meet the requirements of section 401(l)?
If N/A, do not complete lines 10b through 10f. If "Yes" or "No," complete lines 10b through 10f. (See instructions.)
- b** In the case of a defined contribution plan, does the excess contribution percentage exceed the base contribution percentage by a uniform amount that does not exceed the maximum excess allowance?
Base Contribution Percentage _____ Excess Contribution Percentage _____
- c** In the case of a defined benefit excess plan, does the excess benefit percentage exceed the base benefit percentage by a uniform amount no greater than the maximum excess allowance?
Base Benefit Percentage _____ Excess Benefit Percentage _____
- d** In the case of a defined benefit offset plan, are the gross benefit percentage and the offset uniform and is the offset less than the maximum offset allowance?
Gross Benefit Percentage _____ Offset _____
- e** What is the plan's integration/offset level? _____
- f** In the case of a defined benefit plan, does the plan adjust the 75% factor for benefits commencing at ages other than social security retirement age in accordance with Treasury Regulations section 1.401(l)-3(e)?

11 General eligibility requirements—Complete lines 11a, 11b, and 11c below.

- a** Check one box:
 - (1) All employees
 - (2) Hourly rate employees only
 - (3) Salaried employees only
 - (4) Other (Specify) _____
- b** Length of service (number of years) _____ N/A
- c** Minimum age (Specify) _____ N/A

12 Vesting:

Check one box to indicate the vesting provisions of the plan:

- a** Full and immediate.
- b** Full vesting after 2 years of service.
- c** Full vesting after 3 years of service.
- d** Full vesting after 5 years of service.
- e** 6 year graded vesting.
- f** 3 to 7 year graded vesting.
- g** Other (Specify) (See instructions and attach schedule.)

13 Benefits and requirements for benefits:

- a** For defined benefit plans—Method for determining accrued benefit: _____
 - (1) Benefit formula at normal retirement age is _____
 - (2) Benefit formula at early retirement age is _____
 - (3) Normal form of retirement benefit is _____
- b** For defined contribution plans—Employer contributions:
 - (1) Profit-sharing or stock bonus plan contributions are determined under:
 - A definite formula An indefinite formula Both
 - (2) Money purchase—Enter rate of contribution _____
 - (3) State target benefit formula

14 Miscellaneous Provisions:

N/A	Yes	No

- a** Does any amendment to the plan reduce or eliminate any section 411(d)(6) protected benefit? (See instructions.)
- b** Are contributions or benefits allocated on the basis of total compensation within the meaning of section 414(s)? If "No," explain. (See instructions.)
- c** Are forfeitures allocated, in the case of a defined contribution plan, on the basis of total compensation within the meaning of section 414(s)? If "No," explain
- d** Are trust earnings and losses allocated on the basis of account balances in a defined contribution plan?
- e** Is this plan or trust currently under examination or is any issue related to this plan or trust currently pending before the Internal Revenue Service, the Department of Labor, the Pension Benefit Guaranty Corporation, or any court? If "Yes," attach an explanation
- f** Does the plan comply with the annual compensation limit of section 401(a)(17)? (See instructions.)
- g** If this is a defined benefit plan, does the plan contain the pre-termination restrictions of Treasury Regulations section 1.401(a)(4)-(5)(b)?

Procedural Requirements Checklist

This checklist identifies certain basic data required to process this application. The checklist identifies items that **MUST** be included with the application. Completion of this checklist is optional and is for the benefit of the plan sponsor.

	Yes	No
a Is Form 5302 , Employee Census, attached?	<input type="checkbox"/>	<input type="checkbox"/>
b Is Form 8717 , User Fee for Employee Plan Determination Letter Request, and the appropriate user fee attached?	<input type="checkbox"/>	<input type="checkbox"/>
c Is a copy of the plan attached? (Initial applications and Restated plans only)	<input type="checkbox"/>	<input type="checkbox"/>
d Is a copy of the plan's latest determination letter attached? (Previously approved plans only)	<input type="checkbox"/>	<input type="checkbox"/>
e Are the appropriate certifications, designations, and demonstrations attached?	<input type="checkbox"/>	<input type="checkbox"/>
f Has page one been submitted in duplicate (at least one must be an original)?	<input type="checkbox"/>	<input type="checkbox"/>
g Are both copies of page one of the application signed?	<input type="checkbox"/>	<input type="checkbox"/>
h Is the plan sponsor's 9-digit employer identification number entered on line 1b?	<input type="checkbox"/>	<input type="checkbox"/>
i If appropriate, is Form 2848 , Power of Attorney and Declaration of Representative, attached? See Disclosure Requested by Taxpayer	<input type="checkbox"/>	<input type="checkbox"/>
j Is the effective date of the plan entered on line 4d?	<input type="checkbox"/>	<input type="checkbox"/>
k Affiliated Service Groups, Controlled Groups or Entities Under Common Control —Is the information requested under What To File and the line 6 instructions attached?	<input type="checkbox"/>	<input type="checkbox"/>
l Multiple-Employer Plans —Is the information required under What To File, Specific Plans , item 7 , attached?	<input type="checkbox"/>	<input type="checkbox"/>
m ESOPs —Is Form 5309 , Application for Determination of Employee Stock Ownership Plan, attached?	<input type="checkbox"/>	<input type="checkbox"/>

ALL APPLICATIONS ARE SCREENED BY COMPUTER. FAILURE TO INCLUDE A REQUIRED ITEM WILL RESULT IN THE RETURN OF THIS APPLICATION TO YOU.