

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
_____	_____
Number, street, and room or suite no. (If a P.O. box, see instructions.)	1c Employer's tax year ends-Enter N/A or (MM)
_____	_____
City _____ State _____ ZIP code _____	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) _____	d Enter date plan effective (MMDDYY) _____
c Enter date plan year ends (MMDD) _____	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 3 for flat benefit
Enter 2 for fixed 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 4 for target benefit
Enter 2 for stock bonus	Enter 5 for ESOP
Enter 3 for money purchase	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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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 _____

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.