

**Short Form Application for
Determination for Employee Benefit Plan**
(Other than Plans that Include Self-employed Individuals)
(Under sections 401(a), and 501(a) of the Internal Revenue Code)

For IRS Use Only

File
folder
number ▶

▶ Please complete every item on this form. If an item does not apply, enter N/A.

1 (a) Name, address and ZIP code of employer Telephone number ▶ ()	2 (a) Employer's identification number (b) Employer's tax year ends
(b) Name, address and ZIP code of plan administrator, if other than employer Telephone number ▶ ()	3 Administrator's identification number

(c) Name, address and phone number of person to be contacted if more information is needed:

Name ▶ Telephone number ▶ ()
Address ▶

4 Determination requested for:

- (a)** (i) Initial qualification—date plan adopted ▶
- (ii) Amendment—date adopted ▶
- (iii) If (ii) is checked, enter file folder number ▶
- (b)** Were employees who are interested parties given the required notification of the filing of this application? . Yes No

5 Check appropriate box to indicate the type of plan entity:

- (a)** Single-employer plan
- (b)** Plan of controlled group of corporations or of common control employers
- (c)** Multiple-employer plan
- (d)** Church
- (e)** Governmental organization
- (f)** Other (specify) ▶

6 (a) Name of plan	(b) Plan number ▶
	(c) Plan year ends ▶

7 (a) This is a: (i) <input type="checkbox"/> Master or prototype plan (ii) <input type="checkbox"/> Field prototype plan (iii) <input type="checkbox"/> Other (see instructions)	(b) Letter serial number or notification letter number
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8 (a) Defined benefit plan—Indicate whether: (i) <input type="checkbox"/> Unit benefit (ii) <input type="checkbox"/> Fixed benefit	(iii) <input type="checkbox"/> Flat benefit (iv) <input type="checkbox"/> Other (specify) ▶
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(b) Defined contribution plan—Indicate whether: (i) <input type="checkbox"/> Profit-sharing (ii) <input type="checkbox"/> Money purchase	(iii) <input type="checkbox"/> Stock bonus (iv) <input type="checkbox"/> Target benefit
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(c) (i) If 8(a) (i), (ii), (iii), or (iv) is checked, is this a defined benefit plan covered under the Pension Benefit Guaranty Corporation termination insurance program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not determined	(ii) If 4(a) (ii) and 8(b) (i), (ii), (iii), or (iv) are checked, was the plan covered by the termination insurance program prior to the amendment? <input type="checkbox"/> Yes <input type="checkbox"/> No
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9 Effective date of plan	10 Effective date of amendment
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11 Date plan was communicated to employees ▶
How communicated ▶

12 Integration:
Is this plan integrated with Social Security or Railroad Retirement? Yes No

13 Type of funding entity: (a) <input type="checkbox"/> Trust (b) <input type="checkbox"/> Custodial account	(c) <input type="checkbox"/> Non-trusteed (d) <input type="checkbox"/> Trust with insurance contracts
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14 (a) Does plan provide for maximum limitation under section 415? <input type="checkbox"/> Yes <input type="checkbox"/> No	(b) Do you maintain any other qualified plan(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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.

Signature ▶ _____ Title ▶ _____ Date ▶ _____
Signature ▶ _____ Title ▶ _____ Date ▶ _____

15 Is any issue relating to this plan or trust currently pending before the Internal Revenue Service, the Department of Labor, the Pension Benefit Guaranty Corporation or any Court? Yes No
 If "Yes," attach explanation.

	Number
16 Coverage of plan at (give date) ▶	
(a) Total employed	
(b) Exclusions under plan (do not count an employee more than once):	
(i) Minimum age (specify) ▶ Years of service (specify) ▶	
(ii) Employees included in collective bargaining	
(iii) Nonresident aliens who receive no earned income from United States sources	
(c) Total exclusions, sum of (b)(i) through (iii)	
(d) Employees not excluded under the statute, (a) minus (c)	
(e) Ineligible under plan because of (do not count an employee included in (b)):	
(i) Minimum pay (specify) ▶	
(ii) Hourly-paid	
(iii) Maximum age (specify) ▶	
(iv) Other (specify) ▶	
(f) Employees ineligible, sum of (e)(i) through (iv)	
(g) Employees eligible to participate, line (d) minus line (f)	
(h) Number of employees participating in plan	
(i) Percent of nonexcluded employees who are participating, (h) divided by (d) % Complete (j) only if (i) is less than 70% and complete (k) only if (j) is 70% or more.	
(j) Percent of nonexcluded employees who are eligible to participate, (g) divided by (d) %	
(k) Percent of eligible employees who are participating, (h) divided by (g) % If (i) and (j) are less than 70% or (k) is less than 80%, see instructions.	
(l) Total number of participants, include certain retired and terminated employees (see instructions)	
17 Vesting—Check the appropriate box to indicate the vesting provisions of the plan:	
(a) <input type="checkbox"/> Full and immediate	
(b) <input type="checkbox"/> Full vesting after 10 years of service (see instructions)	
(c) <input type="checkbox"/> 5- to 15-year vesting, i.e., 25% after 5 years of service, 5% additional for each of the next 5 years, then 10% additional for each of the next 5 years (see instructions)	
(d) <input type="checkbox"/> Rule of 45 (see section 411(a)(2)(C)) (see instructions)	
(e) <input type="checkbox"/> For each year of employment, commencing with the 4th such year, vesting not less than 40% after 4 years of service, 5% additional for each of the next 2 years, and 10% additional for each of the next 5 years	
(f) <input type="checkbox"/> Other (specify and see instructions) ▶	
18 Complete only for a plan of more than one employer:	
(a) Total number of participants (include certain retired and terminated employees)	
(b) Participants whose benefits or accounts are fully vested	
(c) Number of contributing employers	