

**Application for Determination for Adopters of  
Master or Prototype, Regional Prototype or Volume  
Submitter Plans**

**(Other than Collectively Bargained Plans)  
(Under sections 401(a) and 501(a) of the Internal Revenue Code)**

**For IRS Use Only**

Department of the Treasury  
Internal Revenue Service

File folder  
number ▶

Case number ▶

**Note:** User fee must be attached to this application. (See Instruction B, "What To File.")

File page 1 of Form 5307 in duplicate.

The information provided herein 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 before submitting this application.

**1a** Name of plan sponsor (employer if single employer plan) \_\_\_\_\_ **1b** Employer identification number \_\_\_\_\_

< \_\_\_\_\_ > < \_\_\_\_\_ >

Address (number and street)

< \_\_\_\_\_ >

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

< \_\_\_\_\_ > < \_\_\_\_\_ > < \_\_\_\_\_ >

**1c** Employer's tax year ends—  
Enter (MM) \_\_\_\_\_

**1d** Telephone number  
( ) \_\_\_\_\_

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

Name \_\_\_\_\_

< \_\_\_\_\_ >

Address (number and street)

< \_\_\_\_\_ >

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_ Telephone number \_\_\_\_\_

< \_\_\_\_\_ > < \_\_\_\_\_ > < \_\_\_\_\_ > < \_\_\_\_\_ >

**3a** Determination requested for (enter applicable number(s) at left and fill in required information.) (See Specific Instructions.)

< \_\_\_\_\_ > Enter 1 for Initial Qualification—Date plan signed \_\_\_\_\_

< \_\_\_\_\_ > Enter 2 for Amendment after Initial Qualification

Date amendment signed \_\_\_\_\_ Date amendment effective \_\_\_\_\_

< \_\_\_\_\_ > Enter 3 for Standardized Plans (section 401(a)(26) plans and nonpaired plans)

**b** Has the plan received a determination letter dated after 1/1/84? (Submit a copy of the latest letter if one was ever received.) Yes < \_\_\_\_\_ > No < \_\_\_\_\_ >

If 3b is no, were required amendments made retroactively effective? Yes \_\_\_\_\_ No \_\_\_\_\_

**c** Have interested parties (as defined in Treasury Regulation 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 < \_\_\_\_\_ >

**4a** Name of plan: \_\_\_\_\_

< \_\_\_\_\_ >

< \_\_\_\_\_ > **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 other (Specify) \_\_\_\_\_

Enter 3 for money purchase

**6a** Is the employer a member of an affiliated service group?  
< \_\_\_\_\_ > Enter 1 if "Yes" Enter 2 if "No"

**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 adopter.  
< \_\_\_\_\_ > Enter 1 if a master or prototype plan Enter 3 if a District approved volume submitter plan

Enter 2 if a regional prototype plan

**8** Enter type of plan.  
< \_\_\_\_\_ > Enter 1 if governmental plan or church plan not subject to ERISA

Enter 2 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 ▶



- 9a Do you maintain any other qualified plan(s)? (See Specific Instructions.) . . . . .  Yes  No  
If "Yes," complete 9b and 9c.
- 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:
  - (i) the top-heavy minimum benefit under the defined benefit plan? . . . . .  N/A  Yes  No
  - (ii) at least a 5% minimum contribution under the defined contribution plan? . . . . .  N/A  Yes  No
  - (iii) the minimum benefit offset by benefits provided by the defined contribution plan? . . . . .  N/A  Yes  No
  - (iv) benefits under both plans that, using a comparability analysis, are at least equal to the minimum benefit? (See Specific Instructions.) . . . . .  N/A  Yes  No
- c Do the provisions of the plan preclude the possibility that the section 415 limitations will be exceeded with respect to any employee who is or has been a participant in this plan and any other qualified plan of the employer? . . . . .  Yes  No

10 COVERAGE (See Specific Instructions.):

- a Is the employer applying the separate line of business rules of section 414(r)? . . . . .  Yes  No  
(If "Yes," see Specific 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 percent or more, proceed to f). . . . .  N/A \_\_\_\_\_ %
- e Divide the percentage of nonhighly compensated employees who benefit under the plan (10d) 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 e 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 ratio in line e 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 lines e, f, or g based on the aggregated coverage of more than one plan? . . . . .  Yes  No  
(If "Yes," see Specific Instructions.)
- i If line e, f, or g is less than .7, does the plan pass the average benefit test? . . . . .  N/A  Yes  No
  - (i) Enter the safe harbor percentage . . . . . \_\_\_\_\_
  - (ii) Enter the average benefit percentage . . . . . \_\_\_\_\_

11 PARTICIPATION (See Specific Instructions.):

- a Is a determination requested as to whether the plan satisfies the participation test under section 401(a)(26) with respect to each of the plan's current benefit structures? . . . . .  Yes  No
- b (For defined benefit plans only) Do at least the lesser of 50 employer's employees or 40 percent of the employer's employees accrue the minimum current accrual under the plan? . . . . .  N/A  Yes  No
- c (For defined benefit plans only) If the answer to b is "No," does the plan satisfy section 401(a)(26) with respect to its prior benefit structure under one of the other tests in the Proposed Regulations under section 401(a)(26). (See Specific Instructions.) . . . . .  N/A  Yes  No

- 12 Is a determination requested as to whether the plan satisfies the coverage or participation tests with respect to former employees benefiting under the plan? . . . . .  Yes  No  
If "Yes," has a demonstration been attached showing how the plan satisfies sections 410(b) and 401(a)(26) with respect to former employees? . . . . .  N/A  Yes  No

13 Miscellaneous provisions:

N/A Yes No

a Does any amendment to the plan reduce or eliminate any section 411(d)(6) protected benefit? (See Specific Instructions.) . . . . .

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b Are contributions or benefits allocated on the basis of total compensation within the meaning of section 414(s)? If "No," explain. (See Specific Instructions.) . . . . .

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c 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 explanation . . . . .

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Signature Title Date

## Procedural Requirements Checklist

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

	Yes	No
a. Have you attached <b>Form 5302</b> , Employee Census? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you attached the appropriate user fee and <b>Form 8717</b> , User Fee for Employee Determination Letter Request? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
c. <b>Master or Prototype or Regional Prototype Plans</b> —Have you attached a copy of the adoption agreement? (See General Instruction B.5.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you attached a copy of the master or prototype, regional prototype or volume submitter letter? (See General Instruction B.7.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
e. Have you attached a copy of the plan's latest determination letter? (Previously approved plans only) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
f. Have you submitted page one in duplicate (at least one copy must be an original)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
g. Have you signed both copies of page one of the application? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
h. Have you entered the plan sponsor's 9-digit employer identification number on line 1b? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
i. If appropriate, have you attached <b>Form 2848</b> , Power of Attorney and Declaration of Representative, or <b>Form 2848-D</b> , Tax Information Authorization and Declaration of Representative? (See General Information.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
j. Have you entered the effective date of the plan on line 4d? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
k. <b>Affiliated Service Groups, Controlled Groups or Entities Under Common Control</b> —Have you attached the information requested in General Instructions B.II "What To File" and item 6 of the Specific Instructions? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
l. <b>Volume Submitter Plans</b> —Have you attached a copy of the plan or trust instrument? (See General Instruction B.I.6.) . . . . .	<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.**