



Employee Benefit Administrators, Actuaries and Consultants

Request for Information

(Confidential)

Fax or mail the completed questionnaire and the attached employee census to the address indicated below.

EMPLOYER LEGAL NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ COUNTY _____

MAILING ADDRESS (if different) _____

PHONE # _____ FAX # _____ CONTACT PERSON _____

EMAIL ADDRESS _____

TYPE OF EMPLOYER ORGANIZATION (For tax purposes):

- | <u>FOR PROFIT</u> | <u>NOT FOR PROFIT</u> |
|---|--|
| <input type="checkbox"/> C Corporation | <input type="checkbox"/> Governmental Entity |
| <input type="checkbox"/> S Corporation | <input type="checkbox"/> Church |
| <input type="checkbox"/> Professional Service | <input type="checkbox"/> Educational |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Charitable |
| <input type="checkbox"/> Sole Proprietor | <input type="checkbox"/> Other _____ |

Date Business Began _____ Date of Incorporation _____

Fiscal Year Ends _____ Nature of Business _____

NAIC Business Code _____ Employer Tax I.D. Number _____

Basis of Accounting Cash Accrual

PLAN DESIGN OBJECTIVES OF EMPLOYER

What are the Employer objectives in establishing this plan?

(Check those that apply; rank in ascending order starting with 1 for highest priority)

- _____ Tax Deduction for Employer
- _____ Accumulate substantial retirement income for owner(s)
- _____ Create a non-business asset for owner(s)
- _____ Provide retirement security for employees
- _____ Attract and retain employees
- _____ Benefit key employees
- _____ Allow employee pretax savings
- _____ Replace lost IRA deductions
- _____ Transfer of business to family members
- _____ Buyout of major stockholder's interest

When does the Employer intend to adopt the plan? _____

When does the Employer wish to make the first contribution? _____

Who do you want as trustee(s) on the plan? _____

Does the Employer want a specific type of plan and if so what type?

- Most Suitable Plan
- Profit Sharing Plan
- Defined Benefit
- Employee Stock Ownership Plan
- 401(k) Plan
- SEP/SIMPLE

Check here if allocation to key employees is to be maximized. (Cross-tested or integrated)

Who does the Employer want to be eligible for this plan?

- All employees initially eligible
- All employees employed on _____ date are eligible
- Waiting period of _____ months and attainment of age _____
- Exclude: _____

OWNERSHIP, AFFILIATED ORGANIZATION AND FAMILY INFORMATION

Provide the ownership breakdown of the business for the plan year being valued.

- a. For a corporation, provide the breakdown of stock ownership.
- b. For a not-for-profit organization, skip this section.
- c. For a non-incorporated business, provide the capital or profit interest breakdown.

NAME	STOCK %
_____	_____
_____	_____
_____	_____
	100%

Does the Spouse of any controlling owner have an ownership interest in any other business? _____ (Y/N)

FAMILY MEMBERS

Important - Currently, family members (lineal ascendants/descendants and spouses thereof) who are employed and participating in the plan(s) can, under certain circumstances, be tagged as highly compensated and/or key employees. Therefore, the following information must be completed.

Are any employees related (spouse, child, parent, grandparent, grandchild, or in-laws) to any of the following (Highly Compensated or HCE) or Key Employees, defined as:

_____ A 5% or more owner _____ An employee earning over \$85,000

Name: _____ Related to: _____ Type of Relationship: _____

Name: _____ Related to: _____ Type of Relationship: _____

Name: _____ Related to: _____ Type of Relationship: _____

EXISTING PLAN

(If possible, send a copy of the Plan Document and/or Summary Plan Description with this questionnaire)

What type of plan does the employer currently have? _____

Effective Date of Plan: _____ Trust EIN: _____

Will the plan under consideration: [] replace, [] enhance or [] supplement the existing plan(s)?

Check areas of concern, if any, with the existing plan:

- Analysis in light of objectives indicated
- Requires redesign due to changed business circumstances
- Review administrative services
- Review of plan for compliance with recent legislative changes

Does the Employer have a health plan that is partially funded by employee contributions? _____

If yes, does Employer want a quote on a Section 125 Cafeteria program? _____

CLIENT ADVISORS

Accountant _____

Company _____

Address _____

Phone () _____/Ext. _____

Fax () _____

E-Mail _____

Attorney _____

Company _____

Address _____

Phone () _____/Ext. _____

Fax () _____

E-Mail _____

Investment Advisor _____

Company _____

Address _____

Phone () _____/Ext. _____

Fax () _____

E-Mail _____

Insurance Agent _____

Company _____

Address _____

Phone () _____/Ext. _____

Fax () _____

E-Mail _____

