



**NON-DISCRIMINATION TESTING QUESTIONNAIRE**

Please complete the questionnaire below and provide information where requested. This data will allow us to conduct all required non-discrimination testing that applies to your plan, and to file Form 5500. Please review data already entered and make corrections as needed.

**Company Name:** \_\_\_\_\_

**Plan Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**Employer ID:** \_\_\_\_\_ **Business Activity Code:** \_\_\_\_\_

**Plan Trustee:** \_\_\_\_\_ **Plan No:** \_\_\_\_\_

**Plan Administrative Contact:** \_\_\_\_\_

**Email Contact:** \_\_\_\_\_

**Entity Type:** \_\_\_\_\_ **Fiscal Year End:** \_\_\_\_\_

1. Did the company receive services of leased employees other than from your current Professional Employer Organization during the plan year?  Yes  No

2. Has your business changed in the past 12 months? (ie: sold, merged, acquired)  Yes  No

(If yes, please provide names of entities, date of merger, sale or acquisition, and any other details related to change.)

\_\_\_\_\_

3. Has your business changed its entity classification (corporation, partnership, etc.....) in the past 12 months?  Yes  No

(If yes, please provide date and type of change.)

\_\_\_\_\_

4. Does your company have a Section 125 (Cafeteria) Plan?  Yes  No

5. Will your company be filing an extension to the company's tax return?  Yes  No

**Prepared By:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

6. Do you maintain any other qualified retirement plans?  Yes  No

(If yes, please indicate name and type of plan(s))

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Controlled Group: If the company or its principals also own other businesses, please indicate ownership percentage, relationship and number of employees below. Or, indicate below if there are no changes from last year.

Owner - this Company	Other Company Owned	% Owned - Other Company	# of Employees
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Please provide a list of disabled, deceased or retired employees during the plan year.

Participant	Disabled	Deceased	Retired
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Please provide a list of employees who were activated for military service.

Participant	SSN	Date Activated	Date Returned
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

10. Matching Formula: \_\_\_\_\_% up to \_\_\_\_\_%

11. Has your matching formula changed at any time during the plan year?  Yes  No

(If yes, please indicate new formula and effective date of change.)

\_\_\_\_\_  
\_\_\_\_\_

12. Will your company be making a discretionary profit sharing or year-end matching contribution for the plan year?  Yes  No

(If yes, please indicate the projected date for this contribution and the projected percentage or dollar amount.)

\_\_\_\_\_  
\_\_\_\_\_

**Notes to AMI:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Prepared By:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_