



**AMI Benefit Plan
Administrators, Inc.**

More than just administration . . .

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: _____

Trustee Email: _____

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

Prepared By: _____ **Title:** _____ **Date:** _____

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

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

6. 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 |
|----------------------|---------------------|-------------------------|----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

7. 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"/> |

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

| Participant | SSN | Date Activated | Date Returned |
|-------------|-------|----------------|---------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

9. 2011 Matching Formula: ____% up to ____%

10. 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.)

11. Will your company be making a discretionary profit sharing or year-end matching contribution for the 2011 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:** _____