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: ______________________________

Entity Type: ______________ **Fiscal Year End:** ______________

1. Total number of employees of the employer as of plan year end: __________

   (Please include part time, seasonal, leased, self-employed, and collectively bargained employees.)

2. Did the company receive services of leased employees during the plan year? ☐ Yes ☐ No

3. 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.)

   ____

   ____

4. 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.)

   ____

   ____

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

   (If yes, please list each employee's total deduction for the plan year on the attached census sheet. A listing of each employee's deduction is also acceptable.)

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

Prepared By:__________________________ **Title**:____________________ **Date**:____________

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

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

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8. 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

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

Participant	Disabled	Deceased	Retired
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

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

Participant	SSN	Date Activated	Date Returned

11. Amount of Fidelity Bond: ______________________

12. Matching Formula: _____% up to _____%

13. 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.)

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____

14. 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.)

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Notes to AMI:

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Prepared By:__________________________ **Title**:____________________ **Date**:____________

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