



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. Total number of employees of the employer as of: **12/31/11** _____
(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:** _____

7. If your plan is a large plan that requires an audit, is your company retaining the same independent firm to conduct your plan audit? Yes No

(If no, please provide the name, address, phone number, and contact person if available of your new independent auditing firm)

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

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

9. 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

10. 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"/>
_____	<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"/>

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

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

Prepared By: _____ Title: _____ Date: _____

12. Please provide a list of employees who received severance pay and/or 3rd party sick pay as part of their W-2 or other income.

Participant	SSN	Severance	3 rd Party Sick Pay	Amount of Severance / 3 rd Party Sick Pay
		<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"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

13. Amount of Fidelity Bond: _____

14. 2011 Matching Formula: _____ % up to _____ %

15. 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.)

16. 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.)

Please note: Employer contributions are deductible if funds are deposited on or before the due date of your business tax return including extensions.

Notes to AMI:

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