

PLAN DESIGN QUESTIONNAIRE

Contact Name _____

Plan Administrator: Employer Committee Other: _____

Type of Plan _____ 401(k) _____ Profit Sharing _____ Money Purchase Pension
 _____ Defined Benefit Pension _____ Other: _____

I. Basic Employer Information

A. Employer: _____

B. Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Fax#: _____

Email: _____

C. Employer ID#: _____ Plan/Trust ID#: _____

D. Form of Business: ___ Corporation ___ S Corp ___ LLC
 ___ Partnership ___ Sole Proprietorship ___ Other: _____

E. Controlled Group/Affiliated Service Group: ___ Yes ___ No

F. Name of Plan: _____

G. Existing Plan or New Plan: _____ Original Effective Date: _____

H. Date Business Commenced: _____

I. Plan Year End _____ Employer Fiscal Year: _____

J. Business Code (6 digits) _____

K. Plan Number _____

Trustee(s): _____
