

EMPLOYER / PLAN INFORMATION QUESTIONNAIRE

COMPLETE ONE QUESTIONNAIRE FOR EACH PARTICIPATING OR RELATED EMPLOYER

Attach Additional Sheets of Information If More Space Is Needed

Name of Plan:_____

Plan Number: ____ (3 Digits - e.g. 001, 002, etc.) **Trust ID#** ____ - _____

☐ If None, I Will Apply for One

[] KARDAN Should Apply for One

(\$75 fee applies)

EMPLOYER INFORMATION

Name of Employer: _____

Address of Employer: _____

Phone Number: () _____ - _____

Fax Number: () _____ - _____

Employer Tax I.D.: ____ - ____

Business Code: _____ (6 Digits)

Date Business Started: ____/____/____

State of Legal Construction: _____

Employer's Fiscal Year End: ____ / ____

Type of Entity: ☐ C Corporation

☐ Partnership

☐ Sole Prop.

[] S Corporation

[] P.C. or P.A.

☐ Non-Profit

[] LLC

[] LLP

☐ Other:

PLAN TRUSTEE INFORMATION: List below each Trustee of the Plan.

NAME OF TRUSTEE	ADDRESS (If different from Employer)

SHAREHOLDER INFORMATION: List below each shareholder or owner (S/H) of the employer. Enter the percentage (%) of the value of outstanding stock or the % of the total combined voting power of stock, if greater. If the employer is not a corporation, enter the % of the capital or profits interest. Include any former employees who have owned a share of the business any time in the last five years. Also list below each employee who is a spouse, lineal ascendant or descendant of a S/H, or a spouse of a lineal ascendant or descendant of a S/H and indicate his or her relationship to each S/H.

[illegible]

OFFICER INFORMATION: List below all officers. Include administrative executives who are in regular and continued service, regardless of title. An employee who merely has the title of an officer but no real authority should not be included. Unincorporated entities may have officers for this purpose.

NAME OF OFFICER	TITLE, IF ANY

OTHER PLANS MAINTAINED BY EMPLOYER: List below the name, plan type (defined benefit, profit sharing, money purchase, etc.), and the years the plan was in effect (e.g. 1994-1999) for each plan the employer or any predecessor business (whether or not incorporated) currently maintains, or has ever maintained. If none, enter "NONE".

NAME OF PLAN	PLAN #	TYPE OF PLAN	YEARS IN EFFECT

RELATED CORPORATIONS OR BUSINESSES: The employer is a member of (consult with your accountant or legal advisor):

- ☐ 1. Controlled Group of Corporations or Businesses
- ☐ 2. Affiliated Service Group
- ☐ 3. Neither a Controlled Group nor Affiliated Service Group

Indicate below each business in which any shareholder or owner of the employer has or has ever had an interest of 5% or more. If none, enter "NONE". Indicate which businesses are part of a controlled (CG) or affiliated service group (ASG) with the employer. For each business listed, a separate completed questionnaire will be required. You may use photocopies of this form.

NAME OF BUSINESS	CG/ASG	SHAREHOLDER	% OWNED

AN OFFICER/OWNER OR AN AUTHORIZED REPRESENTATIVE MUST SIGN BELOW

To the best of my knowledge, the above information is complete and accurate. I understand that this information is required to properly design and administer qualified retirement plans, and that providing inaccurate or incomplete information may result in the future disallowance of tax deductions for plan contributions, and possible disqualification of the plan and trust.

Date

Signature

Name, Title (Please Print)