



Administrative, Consulting & Actuarial Services

445 Broad Hollow Road, Suite 8 • Melville, New York 11747 • 631-465-0850 • Fax 631-465-0855 • info@pensionreviewservices.com

PENSION QUESTIONNAIRE

1. We need to know to whom we should address pension plan correspondence and from whom we should request data. Please list this information below:

	<u>Correspondence</u>	<u>Request for Data</u>
Name:	_____	_____
Co. Name:	_____	_____
Street Address,	_____	_____
Town, State Zip Code	_____	_____
Email:	_____	_____
Phone Number:	_____	_____
Fax Number:	_____	_____

2. Exact Legal Name of Company: _____

Address & telephone number: _____

(Please attach business card)

3. Describe principal business activity: _____

4. Business Code: _____

5. Type of company: C-Corporation S-Corporation Partnership LLC LLP
 Sole Proprietorship Tax-Exempt Organization, Internal Revenue Code § _____

If LLC, are owners paid via W-2 or K-1? W-2 K-1

6. What is the original date of incorporation of the company? If not incorporated, what is the date the business started? _____

7. State of incorporation, or state of principal office where doing business: _____

8. Name of predecessor company (if applicable): _____

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9. **Original date of incorporation of predecessor (if applicable):** _____

10. **Fiscal (tax) year of company:** _____

11. **Owners and officers of corporation (please list names, titles, & percentage of ownership):**

<u>Name</u>	<u>Title</u>	<u>Ownership %</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. **Please list all employees who are related and their relationships:**

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

13. **Employer (tax) identification number:** _____
(not Social Security Number)

14. **Is there any degree of common ownership or affiliation with other entities?** Yes No
If yes, name of entity: _____

Ownership: _____

Other: _____

If more than one entity, indicate on a separate page.

15. **Any leased employees?** Yes No

If yes, explain: _____

16. **Any union employees?** Yes No

If yes, should the union employees be excluded from the plan? Yes No

17. **Any employees who are non-resident aliens?** Yes No

18. **Number of hours of services required for a year of service:**

a) for eligibility _____ **(cannot be greater than 1000)**

b) for benefit accrual/allocation _____ **(cannot be greater than 1000)**

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19. **Name of plan trustees:** _____

20. **Advisors:**
Please provide the information requested about your advisors.

	<u>Accountant</u>	<u>Attorney</u>	<u>Financial/Insurance Provider</u>
Name:	_____	_____	_____
Co. Name:	_____	_____	_____
Address:	_____	_____	_____
With suite #:	_____	_____	_____
Email:	_____	_____	_____
Phone No.:	_____	_____	_____
Fax No.:	_____	_____	_____

*** We will automatically cc any advisors listed as well as allow portal access to these advisors. If you want to place some limitations on this policy, please advise us.*

21. **What payroll provider do you use?** _____

22. a) **Is there another plan (including Keogh plans, SEPs, and Cafeteria plans)?** Yes No
If yes, please list and include trust EIN and plan number (if applicable). If more than one other plan, indicate on separate page.

Name of plan: _____
Trust EIN: _____ Plan number: _____

b) **If (a) is yes, who administers the plan?** _____

c) **Were there any other qualified plans that were terminated in the past?** Yes No

Types of terminated plans: _____

Dates of termination: _____

Completed by: _____

Date: _____