

Application for Determination for Collectively Bargained Plan

OMB No. 1545-0534
Expires: 11-30-95

Department of the Treasury
Internal Revenue Service

(Under sections 401(a) and 501(a) of the Internal Revenue Code)

For IRS Use Only

File folder number ►
Case number ►

File page 1 of Form 5303 in duplicate.

NOTE: User fee must be attached to this application. (See "What To File.") Enter amount of user fee submitted _____

The information provided on this form will be read by a computer. Therefore page 1 must be typed (except the signature). Enter information exactly as requested and only in the space provided. Do not type in areas that are shaded.

Review the Procedural Requirements Checklist on page 3 before submitting this application.

1a Name of plan sponsor (employer if single employer plan)

1b Employer identification number

Number, street, and room or suite no. (If a P.O. box, see instructions)

1c Employer's tax year ends—Enter N/A or (MM)

City State ZIP Code

1d Telephone number

()

2 Person to be contacted if more information is needed. (See instructions.)

(If the same as line 1a, leave blank. Complete even if Power of Attorney is attached):

Name

Number, street, and room or suite no. (If a P.O. box, see instructions)

City State ZIP Code Telephone number

()

3a Determination requested for (enter applicable number(s) at left and fill in required information).

(See instructions.)

Enter 1 for Initial Qualification—Date plan signed

Enter 2 for Amendment after initial qualification—Is plan restated? Yes No

Date amendment signed Date amendment effective

Enter 3 for Termination of multi-employer or multiple-employer-collectively-bargained plan covered by PBGC insurance.

Date termination effective

Enter 4 for Partial Termination—Date effective

b Has the plan received a determination letter? If "Yes," submit a copy of the latest letter Yes No

c Have interested parties (defined in Treasury Regulation section 1.7476-1) been given the required notification of this application? Yes No

d Does the plan have a cash or deferred arrangement, or employee or matching contributions (section 401(k) or (m))?. Yes No

e Does this plan benefit noncollective bargained employees or are more than 2% of the employees who are covered under a collective bargaining agreement professional employees (see instructions)? Yes No

4a Name of Plan:

b Enter plan number (3 digits) **d** Enter date plan effective(MMDDYY)

c Enter date plan year ends (MMDD) **e** Enter number of participants in plan

5a If this is a defined benefit plan, enter the appropriate number in box at left.

Enter 1 for unit benefit Enter 3 for flat benefit

Enter 2 for fixed benefit Enter 4 for other (Specify)

b If this is a defined contribution plan, enter the appropriate number in box at left.

Enter 1 for profit sharing Enter 4 for target benefit

Enter 2 for stock bonus Enter 5 for ESOP

Enter 3 for money purchase Enter 6 for other (Specify)

6 Enter type of plan:

Enter 1 if governmental plan Enter 2 if church plan not subject to ERISA (see instructions)

Enter 3 if multiple-employer-collectively-bargained plan (other than multi-employer plan)

Enter 4 if multi-employer plan as described in section 414(f)

Enter 5 if section 412(i) plan

Enter 6 if other

Under penalties of perjury, I declare that I have examined this application, including accompanying statements, and to the best of my knowledge and belief, it is true, correct, and complete. **Both copies of this page must be signed.**

Signature ►

Title ►

Date ►

Instructions are separate. See page 1 for Paperwork Reduction Act Notice.

Cat. No. 11790D

Form **5303** (Rev. 1-93)

[Redacted]

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 < _____ > < _____ >
 Number, street, and room or suite no. (If a P.O. box, see instructions)

< _____ > **1c** Employer's tax year ends—Enter N/A or (MM)
 City State ZIP Code < _____ >

< _____ > < _____ > < _____ > **1d** Telephone number
 ()

2 Person to be contacted if more information is needed. (See **instructions**.)
 (If the same as line 1a, leave blank. Complete even if Power of Attorney is attached):
 Name
 < _____ >
 Number, street, and room or suite no. (If a P.O. box, see instructions)

< _____ > >
 City State ZIP Code Telephone number

< _____ > < _____ > < _____ > ()

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 (See **instructions**.)

< > Enter 1 for Initial Qualification—Date plan signed _____
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 Date amendment signed _____ Date amendment effective _____
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 Date termination effective _____
 < > Enter 4 for Partial Termination—Date effective _____

b Has the plan received a determination letter? If "Yes," submit a copy of the latest letter Yes < > No < >
c Have interested parties (defined in Treasury Regulation section 1.7476-1) been given the required notification of this application? Yes < > No < >
d Does the plan have a cash or deferred arrangement, or employee or matching contributions (section 401(k) or (m))?. Yes < > No < >
e Does this plan benefit noncollective bargained employees or are more than 2% of the employees who are covered under a collective bargaining agreement professional employees (see instructions)? Yes < > No < >

4a Name of Plan: < _____ >
 < > **b** Enter plan number (3 digits) _____ **d** Enter date plan effective(MMDDYY)
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Under penalties of perjury, I declare that I have examined this application, including accompanying statements, and to the best of my knowledge and belief, it is true, correct, and complete. **Both copies of this page must be signed.**

Signature ► Title ► Date ►

Procedural Requirements Checklist

This checklist identifies certain basic data required to process your application. The checklist identifies items that **MUST** be included with your application. Completion of this checklist is optional and is for the benefit of the plan sponsor.

	Yes	No
1 If required, is Form 5302 , Employee Census attached? (See Specific instructions for line 3e.)	<input type="checkbox"/>	<input type="checkbox"/>
2 Is Form 8717 , User Fee for Employee Plan Determination Letter Request and the appropriate user fee attached?	<input type="checkbox"/>	<input type="checkbox"/>
3 Is a copy of the plan attached? (Initial applications, Restated plans, and Terminating plans)	<input type="checkbox"/>	<input type="checkbox"/>
4 If applicable, is a copy of the amendments attached?	<input type="checkbox"/>	<input type="checkbox"/>
5 Is a copy of the plan's latest determination letter attached? (Previously approved plans only).	<input type="checkbox"/>	<input type="checkbox"/>
6 Are the appropriate certifications, designations, and demonstrations attached?	<input type="checkbox"/>	<input type="checkbox"/>
7 Has page one been submitted in duplicate (at least one must be an original)?	<input type="checkbox"/>	<input type="checkbox"/>
8 Are both copies of page one of the application signed?	<input type="checkbox"/>	<input type="checkbox"/>
9 Is the plan sponsor's 9-digit employer identification number entered on line 1b?	<input type="checkbox"/>	<input type="checkbox"/>
10 If appropriate, is Form 2848 , Power of Attorney and Declaration of Representative, attached? (See General information.)	<input type="checkbox"/>	<input type="checkbox"/>
11 Is the effective date of the plan entered on line 4d?	<input type="checkbox"/>	<input type="checkbox"/>
12 Partial Terminations —Is the information requested under What To File, Specific Plans—Additional Requirements, item 4 on page 2 of the instructions attached?	<input type="checkbox"/>	<input type="checkbox"/>
13 Terminations —Is the information requested under What To File, Specific Plans—Additional Requirements, item 7 on page 2 of the instructions attached?	<input type="checkbox"/>	<input type="checkbox"/>
14 ESOPS only —Is Form 5309, Application for Determination of Employee Stock Ownership Plan attached?	<input type="checkbox"/>	<input type="checkbox"/>

ALL APPLICATIONS ARE SCREENED BY COMPUTER. FAILURE TO INCLUDE A REQUIRED ITEM WILL RESULT IN THE RETURN OF THIS APPLICATION TO YOU.

Coverage (See instructions.)	N/A	Yes	No
7a Does the plan benefit any employee who is not a collectively bargained employee? If "Yes," see instructions			
b Are more than 2% of the employees who are covered under any collective bargaining agreement professional employees? If "Yes," see instructions			

Permitted Disparity	N/A	Yes	No
8a If the plan provides for disparity in contributions or benefits, is the plan intended to meet the requirements of section 401(l)? If N/A, do not complete lines 8b through 8f. If "Yes" or "No," complete lines 8b through 8f, and also see the instructions			
b In the case of a defined contribution plan, does the excess contribution percentage exceed the base contribution percentage by a uniform amount that does not exceed the maximum excess allowance? Base Contribution Percentage _____ Excess Contribution Percentage _____			
c In the case of a defined benefit excess plan, does the excess benefit percentage exceed the base benefit percentage by a uniform amount no greater than the maximum excess allowance? Base Benefit Percentage _____ Excess Benefit Percentage _____			
d In the case of a defined benefit offset plan, are the gross benefit percentile and the offset uniform, and is the offset less than the maximum offset allowance? Gross Benefit percentile _____ Offset _____			
e What is the plan's integration level? _____			
f In the case of a defined benefit plan, does the plan adjust the 75% factor for benefits commencing at ages other than social security retirement age in accordance with Treasury Regulations section 1.401(1)-3?			

General Eligibility Requirements (Complete lines 9a, 9b, and 9c below.)
9a Check one box: (1) <input type="checkbox"/> All employees (2) <input type="checkbox"/> Hourly rate employees only (3) <input type="checkbox"/> Salaried employees only (4) <input type="checkbox"/> Other (Specify) _____
b Length of service (number of years) _____ <input type="checkbox"/> N/A
c Minimum age (Specify) _____ <input type="checkbox"/> N/A

Vesting (Check one box to indicate the vesting provisions of the plan.)
10a <input type="checkbox"/> Full and immediate b <input type="checkbox"/> Full vesting after 2 years of service
c <input type="checkbox"/> Full vesting after 3 years of service d <input type="checkbox"/> Full vesting after 5 years of service
e <input type="checkbox"/> 6 year graded vesting f <input type="checkbox"/> 3 to 7 year graded vesting
g <input type="checkbox"/> Other (Specify—see instructions and attach a schedule)

Benefits and Requirements for Benefits
11a For defined benefit plans—Method for determining accrued benefit: _____ (1) Benefit formula at normal retirement age is _____ (2) Benefit formula at early retirement age is _____ (3) Normal form of retirement benefit is _____
b For defined contribution plans—Employer contributions: (1) Profit-sharing or stock bonus plan contributions are determined under: <input type="checkbox"/> A definite formula <input type="checkbox"/> An indefinite formula <input type="checkbox"/> Both (2) Money purchase—Enter rate of contribution _____ (3) State target benefit formula _____

Miscellaneous Provisions	N/A	Yes	No
12a Does any amendment to the plan reduce or eliminate any section 411(d)(6) protected benefit? (See instructions .)			
b Are contributions or benefits allocated on the basis of total compensation within the meaning of section 414(s)? If "No," explain. (See instructions .)			
c Are forfeitures allocated, in the case of a defined contribution plan, on the basis of total compensation within the meaning of section 414(s)? If "No," explain			
d Are trust earnings and losses allocated on the basis of account balances in a defined contribution plan?			
e Is this plan or trust currently under examination or is any issue related to this plan or trust currently pending before the Internal Revenue Service, the Department of Labor, the Pension Benefit Guaranty Corporation, or any court? If "Yes," attach explanation			