



Retirement Plan Specialists, Inc.

Employee Benefit Administrators, Actuaries and Consultants

Request for Information

(Confidential)

Fax or mail the completed questionnaire and the attached employee census to the address indicated below.

EMPLOYER LEGAL NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ COUNTY _____

MAILING ADDRESS (if different) _____

PHONE # _____ FAX # _____ CONTACT PERSON _____

EMAIL ADDRESS _____

TYPE OF EMPLOYER ORGANIZATION (For tax purposes):

- | <u>FOR PROFIT</u> | <u>NOT FOR PROFIT</u> |
|---|--|
| <input type="checkbox"/> C Corporation | <input type="checkbox"/> Governmental Entity |
| <input type="checkbox"/> S Corporation | <input type="checkbox"/> Church |
| <input type="checkbox"/> Professional Service | <input type="checkbox"/> Educational |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Charitable |
| <input type="checkbox"/> Sole Proprietor | <input type="checkbox"/> Other _____ |

Date Business Began _____ Date of Incorporation _____

Fiscal Year Ends _____ Nature of Business _____

NAIC Business Code _____ Employer Tax I.D. Number _____

Basis of Accounting Cash Accrual

PLAN DESIGN OBJECTIVES OF EMPLOYER

What are the Employer objectives in establishing this plan?

(Check those that apply; rank in ascending order starting with 1 for highest priority)

- _____ Tax Deduction for Employer
- _____ Accumulate substantial retirement income for owner(s)
- _____ Create a non-business asset for owner(s)
- _____ Provide retirement security for employees
- _____ Attract and retain employees
- _____ Benefit key employees
- _____ Allow employee pretax savings
- _____ Replace lost IRA deductions
- _____ Transfer of business to family members
- _____ Buyout of major stockholder's interest

When does the Employer intend to adopt the plan? _____

When does the Employer wish to make the first contribution? _____

Who do you want as trustee(s) on the plan? _____

Does the Employer want a specific type of plan and if so what type?

- Most Suitable Plan
- Profit Sharing Plan
- Defined Benefit
- Employee Stock Ownership Plan
- 401(k) Plan
- SEP/SIMPLE

Check here if allocation to key employees is to be maximized. (Cross-tested or integrated)

Who does the Employer want to be eligible for this plan?

- All employees initially eligible
- All employees employed on _____ date are eligible
- Waiting period of _____ months and attainment of age _____
- Exclude: _____

OWNERSHIP, AFFILIATED ORGANIZATION AND FAMILY INFORMATION

Provide the ownership breakdown of the business for the plan year being valued.

- a. For a corporation, provide the breakdown of stock ownership.
- b. For a not-for-profit organization, skip this section.
- c. For a non-incorporated business, provide the capital or profit interest breakdown.

NAME	STOCK %
_____	_____
_____	_____
_____	_____
	100%

Does the Spouse of any controlling owner have an ownership interest in any other business? _____ (Y/N)

FAMILY MEMBERS

Important - Currently, family members (lineal ascendants/descendants and spouses thereof) who are employed and participating in the plan(s) can, under certain circumstances, be tagged as highly compensated and/or key employees. Therefore, the following information must be completed.

Are any employees related (spouse, child, parent, grandparent, grandchild, or in-laws) to any of the following (Highly Compensated or HCE) or Key Employees, defined as:

_____ A 5% or more owner _____ An employee earning over \$85,000

Name: _____ Related to: _____ Type of Relationship: _____

Name: _____ Related to: _____ Type of Relationship: _____

Name: _____ Related to: _____ Type of Relationship: _____

EXISTING PLAN

(If possible, send a copy of the Plan Document and/or Summary Plan Description with this questionnaire)

What type of plan does the employer currently have? _____

Effective Date of Plan: _____ Trust EIN: _____

Will the plan under consideration: [] replace, [] enhance or [] supplement the existing plan(s)?

Check areas of concern, if any, with the existing plan:

- Analysis in light of objectives indicated
- Requires redesign due to changed business circumstances
- Review administrative services
- Review of plan for compliance with recent legislative changes

Does the Employer have a health plan that is partially funded by employee contributions? _____

If yes, does Employer want a quote on a Section 125 Cafeteria program? _____

CLIENT ADVISORS

Accountant _____

Company _____

Address _____

Phone () _____/Ext. _____

Fax () _____

E-Mail _____

Attorney _____

Company _____

Address _____

Phone () _____/Ext. _____

Fax () _____

E-Mail _____

Investment Advisor _____

Company _____

Address _____

Phone () _____/Ext. _____

Fax () _____

E-Mail _____

Insurance Agent _____

Company _____

Address _____

Phone () _____/Ext. _____

Fax () _____

E-Mail _____

Employee Census

Employee's Name	Sex	Date of Birth	Date of Hire	Gross Compensation	Date of Termination	Hours Worked	Salary Deferral %

Signature of Employer

Date

Additional Comments:

Mail or fax this completed and signed form to the address listed below.

Retirement Plan Specialists, Inc.
815 Eyrie Drive, Suite 2
Oviedo, FL 32765

Fax-(407) 366-5154
Toll Free Fax- (866) 236-1412