



Admin America Form 5500 Preparation Service – Data Gathering Form

Has the Plan Sponsor Filed a Form 5558 Request for an Extension of Time to File Yes *(please provide a copy of the form)* No

Plan Sponsor Information:

Full Legal Name:

Mailing Address:

City, State, Zip Code

Contact Information For The Individual Who Will Sign Form 5500 as Plan Administrator:

Name:

Title:

Telephone Number:

Direct e-mail address:

Plan Information:

Name of Welfare Plan *(i.e. ABC Company's Welfare Benefits Plan)*

Federal EIN:

Business Code (six digits):

(A list of the current business codes can be accessed online at <http://www.dol.gov/ebsa/pdf/2010-5500inst.pdf> on pages 59-61 of the linked document)

Plan Type (select one):

Single Employer Plan Multi-Employer Plan Multiple-Employer Plan (Union) Direct Filing Entity (rare)

If The Plan Is a Collectively - Bargained Plan Check Here

Does the Plan Have a Wrap Document? Yes No

Effective Date of Plan*:

**(Original start date of Employer Sponsored Plan)*

Plan Number*: 5 (three digits)

**(from ERISA Summary Plan Description/Wrap Document or designated by Plan Sponsor for non-ERISA plans)*

Broker Information:

Broker Name:

Broker e-mail address:

Billing Information:

Billing Contact:

Billing Contact's Email:

PLAN INFORMATION:

(IF MULTIPLE YEAR FILINGS, PLEASE COMPLETE ONE SECTION FOR EACH PLAN YEAR)

Plan Year: _____ **through** _____

Plan Participant¹ Count² ¹ (Participant counts do not include spouses and dependents)
² (Participant counts should reflect the welfare benefit with the highest number of enrolled employees (i.e. 100% employer paid life benefit).

As of the END of the PREVIOUS Plan Year: **Total Participants** _____

As of the BEGINNING of the Plan Year: **Total Participants** _____

As of the END of the Plan Year: **Total Active Participants** _____
Retired or Separated Participants _____

Benefit Types Included In Plan (select all that apply):

- Health (other than dental or vision) HMO contract PPO contract Indemnity contract Dental Vision Life Insurance
 Temporary Disability Long-Term Disability Supplemental unemployment Prescription Drug (stand-alone)
 Stop loss (large deductible plans) other (specify) _____

Are all benefits provided through insurance contracts? Yes No. If No, please indicate which benefits and what the funding mechanism is for those benefits (i.e. Fully Self-Funded; Partially Self-Funded): _____

If Benefits Funded through a Trust, Please Indicate Which Benefits: _____

Number of Schedule A Reports from Carriers Submitted Along with This Form To Admin America: _____

Number of Schedule C Reports From Administrators Along With This Form to Admin America: _____

Number of Other Schedules (if applicable) Along With This Form to Admin America: _____

Plan Year: _____ **Plan Year:** _____ **through** _____

Plan Participant¹ Count² ¹ (Participant counts do not include spouses and dependents)
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As of the BEGINNING of the Plan Year: **Total Participants** _____

As of the END of the Plan Year: **Total Active Participants** _____
Retired or Separated Participants _____

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Number of Schedule C Reports From Administrators Along With This Form to Admin America: _____

Number of Other Schedules (if applicable) Along With This Form to Admin America: _____

Plan Year:

Plan Year:

through

Plan Participant¹ Count ²

¹ (Participant counts do not include spouses and dependents)

² (Participant counts should reflect the welfare benefit with the highest number of enrolled employees (i.e. 100% employer paid life benefit).

As of the **END** of the **PREVIOUS** Plan Year: **Total Participants** _____

As of the **BEGINNING** of the Plan Year: **Total Participants** _____

As of the **END** of the Plan Year: **Total Active Participants** _____

Retired or Separated Participants _____

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Number of Schedule A Reports from Carriers Submitted Along with This Form To Admin America:

Number of Schedule C Reports From Administrators Along With This Form to Admin America:

Number of Other Schedules (if applicable) Along With This Form to Admin America:

Name of the Individual Who Will Sign Form 5500 as Plan Administrator:

Plan Administrator Signature:

Signature Date:

Important Information About Form 5500 Due Dates, Deadline Extensions and Late Returns:

Form 5500s must be electronically filed no later than the last day of the seventh month following the Plan Year (example: July 31 for calendar year plans). For filings due within 15 days, Admin America recommends that the Plan Sponsor file a Form 5558 via U.S. Mail. Form 5558 and related filing instructions can be found online at <http://www.irs.gov/pub/irs-pdf/f5558.pdf>. Only Parts I and II are required to be completed and the form does not require a signature. The Plan Sponsor should request an extension of 2 ½ months in Part II. The extension is automatic. **If the Form 5500 filing is already delinquent** or if the Plan Sponsor has failed to file Form 5500s for prior Plan Years, Admin America strongly recommends that the Plan Sponsor take advantage of the U.S. Department of Labor's Delinquent Filer's Voluntary Compliance (DFVC) Program. The DFVC Program provides for voluntary payment of significantly reduced penalties for late Form 5500 submissions. The DFVC Program is only available to Plan Sponsors who have not previously been notified by U.S. D.O.L. that their Form 5500 is overdue. Admin America is prepared to assist Plan Sponsors with the DFVC Program. More information about the DFVC program can be found online at http://www.dol.gov/ebsa/faqs/faq_dfvc.html.