

Annual Plan Review Questionnaire

Instructions: You have requested Lincoln Financial Group (Lincoln Financial) to complete all necessary nondiscrimination testing and reporting for your 2009 plan year. Please answer all applicable questions and return this questionnaire, along with your electronic census file, to Lincoln Financial **no later than one month after your plan year end**. Lincoln Financial can not guarantee completion of your nondiscrimination testing in time to avoid possible excise taxes if this information is not received by this due date. For example, if your plan year ends on December 31st, the information needs to be returned by January 31st to avoid possible excise taxes. If the questionnaire and census are received more than one month after your plan year end, your nondiscrimination testing and reporting will be completed as soon as administratively possible. If you have questions or are unable to meet the deadline, please contact your Account Manager as soon as possible. An incomplete electronic census file and questionnaire may result in additional processing time and fees. The census file will be returned to you if the correct format is not followed or items are left blank.

Plan name _____

Plan sponsor name _____

Plan sponsor address _____

City _____ State _____ Zip _____

Plan sponsor phone number _____ - _____ - _____

Entity Type: Sole Proprietor Partnership Corporation LLP Other _____
 S Corporation 501(c)(3) LLC Governmental

Plan Type: 401(k) 403 (b) Profit Sharing

(Note: ERISA 403(b) plans only need to complete questions #1 through #10, and #12 of this questionnaire.)

1. What were the dates of your plan year that **started in 2009?**

Date _____ - _____ - _____ (mm, dd, year) to date _____ - _____ - _____ (mm, dd, year)

Check here if your plan year end changed from last year.

2. Does Lincoln Financial maintain your plan document/adoption agreement?

Yes No If no, please supply Lincoln Financial with a copy of your plan document/adoption agreement.

3. Have you ever sent employee or employer contributions to multiple vendors? (Note: For 403(b) plans only.)

Yes No If yes, please list all of your approved vendors and any vendors who should be listed on your Form 5500.

4. In order for Lincoln Financial to complete accurate ADP/ACP test(s), you need to identify highly compensated employees (HCEs) based on the definitions below:

As a general rule, a "highly compensated" employee is defined by the IRC as one who:

- a) Is greater than a five percent (5%) owner in the current plan year or preceding 12-month period; or
- b) Earned more than \$105,000 in the preceding 12-month period. (For a calendar 2009 year end test, compensation earned from 1/1/2008 to 12/31/2008 is the period used to determine who is a highly compensated employee.)

Using the alternative definition of highly compensated employees, the employee must:

- a) Be greater than a five percent (5%) owner in the current plan year or preceding 12-month period; or
- b) Have earned more than \$105,000 and have been in the top-paid twenty percent (20%) of all employees in the preceding 12-month period (if permitted in plan document/adoption agreement).

Please select one of the following:

- No highly compensated employees
- Highly compensated employees are identified on the census

The validation of your highly compensated employee will be made from your prior year census or prior year nondiscrimination testing.

5. In order for Lincoln Financial to complete accurate Top-Heavy and ADP/ACP test(s), you need to identify key employees based on the definitions below. Please keep in mind this may include lineal family members (i.e., father, mother, spouse, children (including legal adoptions) and/or grandparent) of owners who are employed by the Plan Sponsor or any related employer, and who receive compensation from the Plan Sponsor business/organization. (see page 6 and 7) (Note: This is not applicable for 403(b) plans.)

- No key employee(s)
- Yes, key employee(s)

Please provide your plan's key employees below:

(The identification of highly compensated employee will be made from your census or prior year nondiscrimination testing.)

Name	SSN	Key employee code (1, 2, 3, 4 or 5 from below)	Relationship to owner
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____

Key employee codes:

1. A greater than 5% owner.
2. An employee who is a parent, spouse, child (including legal adoptions), grandparent of greater than 5% owner (family attribution – see page 6 and 7).
3. An officer of the company earning more than \$160,000 in 2009.
4. A greater than 1% owner with earnings in excess of \$150,000.
5. An employee who is a parent, spouse, child (including legal adoptions), grandparent of a greater than 1% owner with earnings in excess of \$150,000 (family attribution – see page 6 and 7).

6. If the ADP/ACP test should fail, do you want to: (see page 7)

- Make corrections by 2½ months after the plan year end in order to avoid a penalty; for calendar year plans, this date would be March 15, 2010.
(Census and Questionnaire must be returned by one month after your plan year end.)

For 403(b) only: If you have multiple vendors, who should make the correction:

If affected highly compensated employee does not have account at Lincoln Financial, we will not be able to make correction.

- Make corrections after March 15, 2010. IRS will impose a 10% penalty.
As Plan Administrator, I authorize Lincoln Financial to process the corrective distributions due to failed testing without the need of further authorization or my signature on Lincoln Financial forms unless indicated below.
- I wish to review corrective distributions before they are processed.

7. Census data will be sent approximately ____-____-____ (mm, dd, year)

8. What is your total compensation/earnings required to be reported on an IRS Form 941 for the 2009 plan year end?
(Note: The amount of compensation should generally match to the census total.)

9. If your plan funds or intends to fund employer contributions, please indicate below all necessary contributions for the plan year. (Lincoln Financial will not complete testing until all 2009 contributions are funded.):

Contribution Type	Will contribution be funded for 2009?	Date funded or date intend to fund	Formula (Refer to your plan document/adoption agreement)
Employer Match	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If yes, ____ - ____ - ____ (mm, dd, year)	If yes, _____
Employer Discretionary (i.e., Profit Sharing)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If yes, ____ - ____ - ____ (mm, dd, year)	If yes, _____
Money Purchase	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If yes, ____ - ____ - ____ (mm, dd, year)	
Safe Harbor Match Contribution	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If yes, ____ - ____ - ____ (mm, dd, year)	
Safe Harbor Non-elective Contribution	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If yes, ____ - ____ - ____ (mm, dd, year)	

Would you like Lincoln Financial to calculate any of the following employer contributions based on plan document/adoption agreement?

- Employer Match Yes No
- Employer Discretionary Yes No
- Money Purchase Yes No
- Safe Harbor Match Yes No
- Safe Harbor Non-elective Yes No

10. Is any type of compensation (i.e., overtime, bonuses, pay differentials) excluded when calculating employer contributions? (Refer to your plan document/adoption agreement.)

Yes If yes, list the types of compensation you are excluding according to your plan document/adoption agreement:

No

11. Is your organization part of a controlled group or an affiliated service group? (see page 9 & 10) Yes No
 Lincoln Financial does not make the determination as to whether or not your plan is part of a controlled group or an affiliated service group.

Name of related employer

Participating in plan

- | | |
|-------|----------------------------------------------------------|
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Note: If census data is not submitted for each related employer, Lincoln Financial will not complete the nondiscrimination testing.

Note: If yes, census data must be submitted for each participating employer. If complete census data is not received and retesting is required, additional Lincoln Financial fees may apply.

12. Do you have any employees who have returned from military service and are making up missed contributions?

Yes No

If yes, such individuals may receive make-up employer contributions and/or be given the opportunity to make up elective deferral contributions.

13. Does this plan benefit any Union employees covered by a collective bargaining agreement? Yes No

If yes, are retirement benefits subject to a collective bargaining agreement? Yes No

14. What is your organization's 6-digit IRS business code? _____

(If you are unsure of your business code, please check with your tax advisor or use the IRS-approved code listed on your corporate income tax return. If you need further assistance, Lincoln Financial has provided an IRS listing of all business codes.) (See information beginning on page 19.)

15. Did the plan pay more than \$5,000 from plan assets to any service provider of the plan during the current 2009 plan year?

("Service providers" are accountants, attorneys, etc.) (Note: Not applicable to 457 plans.)

Yes No

If yes, and other than Lincoln Financial, complete the following for each service provider who received more than \$5,000 in fees from the plan: (Please provide an attachment if necessary.)

Name _____

Employer ID number (EIN) _____ (9-digits)

Relationship to Plan Sponsor _____

Gross salary/allowance paid by Plan Sponsor _____

Fees/commissions paid by plan _____

16. Did the Plan Sponsor fail to transmit any participant contributions (deferral and/or loan payments) into the plan within the periods prescribed by the Department of Labor proposed regulations*?

Yes No

If yes, complete the following:

Date of payroll deferral	Amount	Date submitted to Lincoln Financial
____ - ____ - ____ (mm, dd, year)	_____	____ - ____ - ____ (mm, dd, year)
____ - ____ - ____ (mm, dd, year)	_____	____ - ____ - ____ (mm, dd, year)
____ - ____ - ____ (mm, dd, year)	_____	____ - ____ - ____ (mm, dd, year)

Participant contributions are due as of the earliest date on which such contributions can reasonably be segregated from the employer's general assets. The maximum time period is described as the 15th business day of the month following the month in which such amounts would otherwise have been payable to the participant in cash. If participant contributions were deposited after this 15-day period, this may be deemed a "prohibited transaction." Normally, the Plan Sponsor must pay an excise tax and complete additional tax forms (Form 5330).

*Under the proposed regulations, for a small plan, participant contributions that are deposited by the 7th business day following the payroll are deemed to be segregated from employer's general assets. If you believe something like this may have happened to your plan, please contact your Account Manager to discuss the situation.

17. What is the amount of your fidelity bond? \$ _____

(Note: Not applicable to 457 plans.) (see page 12)

18. Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? Yes No

Year _____

19. Does your plan contain life insurance policies? Yes No

If yes, provide the following for each carrier:

Name of carrier _____ Policy number _____

Attach a copy of the Schedule A (this is provided by the life insurance company) to this questionnaire. The Schedule A attachment must be included for Form 5500 purposes.

Complete questions 20 and 21 if plan covers 100 or more eligible participants as of the beginning of the plan year.

(Note: Review line 6 on Form 5500 from previous year.)

20. Please complete the Form 5500 information below.

Auditor's name _____

Address _____

City _____ State _____ Zip _____

Phone _____ - _____ - _____ Employer ID number (EIN) _____ 9-digit

E-mail _____

Check here if your auditor has changed from the prior year. This is reported on Schedule C.

Explanation for change _____

21. The accountant's opinion for this filing will be *(check one)*:

Note: Contact your accountant to determine the type of filing and scope of audit needed.

Unqualified

Qualified

Disclaimer

Adverse

Will the accountant perform a limited scope audit? Yes No

22. Is this plan intended to meet the requirements of 404(c) compliance *(see page 12)*? Yes No

23. We will e-mail the nondiscrimination testing results and Form 5500 to you.

Please provide the e-mail address of the individual who should receive this confidential information

(please let us know if this e-mail address changes)

Please contact your Account Manager if you do not have access to e-mail.

Note: If you currently use Groupnet to submit your census and questionnaire, the results will be sent back to you via the Groupnet site.

I have reviewed the information provided above in the Annual Plan Review Questionnaire for the plan year beginning in 2009 and certify that, to the best of my knowledge, this information is complete and accurate. By typing or signing your name on the Plan Administrator's Signature line you are certifying that the information is complete and accurate and you are agreeing for corrective distributions to be processed according to your election on question #6 in the Annual Plan Review Questionnaire on page 14.

Completed by _____ Title/Position _____

E-mail _____

Plan Administrator's
Signature _____ Date _____ - _____ - _____ *(mm, dd, year)*

Plan Administrator's E-mail _____