



Estimated Premium Payment
(Plans with 500 or more Participants in prior filing year)
For Plan Years Beginning in Calendar Year 2004



Downloaded forms may be filed (see instructions).

<p>1. Plan Sponsor Check for name/address change <input type="checkbox"/></p> <p>Check if you do not want forms and instructions next year <input type="checkbox"/></p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p>	<p>2. Plan Administrator Check for name/address change <input type="checkbox"/></p> <p>Check if same as plan sponsor and go to Item 3 <input type="checkbox"/></p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p>
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3. Employer Identification Number/ Plan Number (EIN/PN)

(a) Enter 9-digit EIN (b) Enter 3-digit PN

(c) Has a plan other than yours ceased to exist in connection with any transfer of assets or liabilities from that plan to this plan since the most recent premium filing? No Yes

If yes, give EIN/PN of each disappearing transferor plan and effective date of transfer, and indicate whether it was a merger (M), consolidation (C), or spinoff (S). (See definitions, pages 7-8.)

Transferor's 9-digit EIN	3-digit PN	M M D D Y Y Y Y	Transfer Type
<input style="width:150px;" type="text"/>	<input style="width:60px;" type="text"/>	<input style="width:150px;" type="text"/>	M C S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

(If more than 1, attach a separate sheet that lists the additional EIN/PNs, dates, and transfer types.)

4. If EIN and PN in item 3 (a) and (b) above are NOT BOTH the same as on most recent premium filing, enter both prior EIN and prior PN.

(a) Prior 9-digit EIN (b) Prior 3-digit PN (c) Effective Date of Change

M M D D Y Y Y Y

5. Plan information

(a) Plan Name

(b) Plan Year Beginning M M D D Y Y Y Y (c) Plan Year Ending

6. Estimated premium for this plan Estimated Participant Count

(a) Single-Employer	\$19.00	X	<input style="width:100%;" type="text"/>	=	\$	<input style="width:100%;" type="text"/>
(b) Multiemployer	\$ 2.60	X	<input style="width:100%;" type="text"/>	=	\$	<input style="width:100%;" type="text"/>

7. Premium credit balance (overpayment) from previous years or other credit
(including estimated short-year credit) (See instructions, pages 8-10.) \$

8. Amount Due

(a) Enter premium payment due (item 6 minus item 7) and submit payment to PBGC. \$

(b) Payment method (Check appropriate box to indicate the method for payment to PBGC.)

Check Electronic Funds Transfer (See instructions.)

Under penalties of perjury (18 U.S.C. 1001), I declare that I have examined items 1-5 and 7 of this form, and to the best of my knowledge and belief they are true, correct and complete.

<input style="width:100%;" type="text"/>	M M D D Y Y Y Y	<input style="width:100%;" type="text"/>
Signature of Plan Administrator	Date	Telephone Number (include Area Code)
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
Print or type first name of individual who signs	Print or type last name of individual who signs	Business E-mail Address (Optional)

