## SCHEDULE T (Form 5500)

Department of the Treasury Internal Revenue Service

**Qualified Pension Plan Coverage Information** 

This form is required to be filed under section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

Official Use Only

OMB No. 1210-0110

2004

This Form is Open to Public Inspection.

For the calendar plan year 2004 or fiscal plan year beginning and end	ing MM/RD/YYYY
A Name of plan	B Three-digit plan number ▶
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number
<ul> <li>Note: If the plan is maintained by:</li> <li>More than one employer and benefits employees who are not collectively-bargained employees, each employer (see the instructions for line 1).</li> <li>An employer that operates qualified separate lines of business (QSLOBs) under Code section 4 for each QSLOB (see the instructions for line 2).</li> </ul>	
1 If this schedule is being filed to provide coverage information regarding the noncollectively bar participating in a plan maintained by more than one employer, enter the name and EIN of the	
1a Name of participating employer	
1b Employer identification number	
2 If the employer maintaining the plan operates QSLOBs, enter the following information:  a The number of QSLOBs that the employer operates is	
•	
<ul> <li>Exceptions—Check the box before each statement that describes the plan or the employer. Als If you check any box, do not complete the rest of this Schedule.</li> <li>The employer employs only highly compensated employees (HCEs).</li> </ul>	so see instructions.
<b>b</b> No HCEs benefited under the plan at any time during the plan year.	
c The plan benefits only collectively-bargained employees.	
d The plan benefits all nonexcludable nonhighly compensated employees of the employ 414(b), (c), and (m)), including leased employees and self-employed individuals.	ver (as defined in Code sections
e The plan is treated as satisfying the minimum coverage requirements under Code sec	etion 410(b)(6)(C).
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 550	00. Cat. No. 22770R Schedule T (Form 5500) 2004

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4	Enter the date the plan year began for which coverage data is being submitted		
_	Did any legand ampleyed parform agricus for the ampleyer at any time during the plan year?	No	
a	The state of the s	INO	
b		No	
С	Complete the following:		
	(1) Total number of employees of the employer (as defined in Code section 414(b), (c), and (m)),		
	including leased employees and self-employed individuals		
	(2) Number of excludable employees as defined in IRS regulations (see instructions)		
	(0) Number of negressively letter considerate line (200) from line (201)		
	(3) Number of nonexcludable employees. (Subtract line 4c(2) from line 4c(1))		
	(4) Number of nonexcludable employees (line 4c(3)) who are HCEs		
	(5) Number of nonexcludable employees (line 4c(3)) who benefit under the plan		
	(b) Hambol of Horizonadable simpleyeds (line 16(6)) who belief and the plantimental line plantiment and the		
	(6) Number of benefiting nonexcludable employees (line 4c(5)) who are HCEs		
d	Enter the plan's ratio percentage and, if applicable, identify below the disaggregated		
ŭ	part of the plan to which the information on lines 4c and 4d pertains (see instructions)		
е	Identify any disaggregated part of the plan and enter the ratio percentage or exception (see instructions).		
	Disaggregated Part: Ratio Percentage: Exception:		
(1)	)		
(0)			
(2)			
(3)	3)%		
f	This plan satisfies the coverage requirements on the basis of (check one):		
(1) the ratio percentage test (2) average benefit test			
	<b>Y</b>		

