

**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

2000

**This Form is Open to
Public Inspection.**

For calendar year 2000 or fiscal plan year beginning _____, and ending _____,	
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

Note: If the plan is maintained by:

- More than one employer and benefits employees who are not collectively-bargained employees, a separate Schedule T may be required for each employer (see the instructions for line 1).
- An employer that operates qualified separate lines of business (QSLOBs) under Code section 414(r), a separate Schedule T may be required for each QSLOB (see the instructions for line 2).

1 If this schedule is being filed to provide coverage information regarding the noncollectively bargained employees of an employer participating in a plan maintained by more than one employer, enter the name and EIN of the participating employer:

1a Name of participating employer	1b Employer identification number
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2 If the employer maintaining the plan operates QSLOBs, enter the following information:

- a** The number of QSLOBs that the employer operates is _____.
- b** The number of such QSLOBs that have employees benefiting under this plan is _____.
- c** Does the employer apply the minimum coverage requirements to this plan on an employer-wide rather than a QSLOB basis? . . . Yes No
- d** If the entry on line 2b is two or more and line 2c is "No," identify the QSLOB to which the coverage information given on line 3 or 4 relates.
►

3 Exceptions -- Check the box before each statement that describes the plan or the employer. Also see instructions.

If you check any box, do not complete the rest of this Schedule.

- a** The employer employs only highly compensated employees (HCEs).
- b** No HCEs benefited under the plan at anytime during the plan year.
- c** The plan benefits only collectively-bargained employees.
- d** The plan benefits all nonexcludable nonhighly compensated employees of the employer (as defined in Code sections 414(b), (c), and (m)), including leased employees and self-employed individuals.
- e** The plan is treated as satisfying the minimum coverage requirements under Code section 410(b)(6)(C).

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v3.2 Schedule T (Form 5500) 2000

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2 8 0 0 0 0 0 1 0 B



4 Enter the date the plan year began for which coverage data is being submitted. Month ____ Day ____ Year ____

a Did any leased employees perform services for the employer at any time during the plan year? Yes No

b In testing whether the plan satisfies the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4), does the employer aggregate plans? Yes No

c 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	c(1)	_____
(2) Number of excludable employees as defined in IRS regulations (see instructions)	c(2)	_____
(3) Number of nonexcludable employees. (Subtract line 4c(2) from line 4c(1))	c(3)	_____
(4) Number of nonexcludable employees (line 4c(3)) who are HCEs	c(4)	_____
(5) Number of nonexcludable employees (line 4c(3)) who benefit under the plan	c(5)	_____
(6) Number of benefiting nonexcludable employees (line 4c(5)) who are HCEs	c(6)	_____

d Enter the plan's ratio percentage and, if applicable, identify the disaggregated part of the plan to which the information on lines 4c and 4d pertains (see instructions) ▶ _____

d	_____	%
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e Identify any disaggregated part of the plan and enter the ratio percentage or exception (see instructions).

(1) Disaggregated part: _____	Ratio % or Exception: _____	e(1)	_____	%
(2) Disaggregated part: _____	Ratio % or Exception: _____	e(2)	_____	%
(3) Disaggregated part: _____	Ratio % or Exception: _____	e(3)	_____	%

f This plan satisfies the coverage requirements on the basis of (check one): **(1)** the ratio percentage test **(2)** average benefit test

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