

Annual Premium Payment

For Plan Years Beginning in Calendar Year 2006

Check for Amended Filing [] Check for Disaster Relief [X] (see instructions) See the 2006 Premium Payment Package for the instructions for Form 1

Photocopies and downloaded forms may be filed (see instructions).

1. Plan Sponsor: Jerry McGyer, 555 Highpoint Rd, Yellowstone, VA 33033
2. Plan Administrator: Shelly Roth, 8899 Smith St, Suite 600, Arlington, VA 44040

3. Employer Identification Number/Plan Number (EIN/PN), Electronic Filing: 11-1111111, 555. Does EIN/PN match entry on 2005 Form 5500? [X] Yes.

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

5. Plan Coverage Status (check one) (a) [X] Covered (b) [] Uncertain

6. Is this the first year's premium filing for this plan? [X] Yes. (a) Plan effective date: 01-01-2006 (b) Plan adoption date: 01-01-2006 (c) Plan coverage date: 01-01-2006

7. Transfers from disappearing plans: 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? [X] Yes. Transferor's 9-digit EIN: 98-7654321, 3-digit PN: 333, M M D D Y Y Y Y: 12-01-2005, Transfer Type: [X] M, [] C, [] S.

8. Business Code and CUSIP number: (a) Enter 6-digit Business Code: 524150 (b) Enter first 6 digits of CUSIP number: 123456

9. Name of Plan: Form1/Sch. A ACM Large Plan

991506

EIN/PN from item 3 (a) and (b)

11-1111111

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10. Name and Phone Number of Plan Contact

(a) Name:

Tyrone Wheat

(b) Area Code and Phone Number

333-333-3333

11. Plan Type (Check appropriate box to indicate type of plan and type of filing.)

(a) Multiemployer plan

(b) Single-Employer plan (Includes Multiple Employer plan)

12. (a) This premium is for the plan year beginning:

MM DD YY 01-01 2006

(b) This premium is for the plan year ending:

MM DD YYYY 12-31-2006

(c) Check here if the plan year beginning date has changed since last filing with PBGC

(d) Adoption date of plan year change:

MM DD YYYY

13. Enter PARTICIPANT COUNT for the plan year specified in item 12.

(See instructions, page 30.)

13

1,000

14. (a) MULTIEMPLOYER premium:

Multiply item 13 by the \$8 premium rate and enter amount 14(a)

(b) SINGLE-EMPLOYER flat-rate premium:

Multiply the participant count in item 13 by \$30. 14(b)

(c) SINGLE-EMPLOYER variable-rate premium:

From Schedule A, item 6 14(c)

(d) SINGLE-EMPLOYER total premium:

Add items 14(b) and 14(c). Enter amount. 14(d)

15. Premium credits (See instructions, page 31.)

(a) Amount paid with 2006 estimated filing 15(a)

(b) Other credit (including any credit claimed in the 2006 estimated filing and any short-year credit). (See instructions, page 31.) 15(b)

(c) Total credit: Add items 15(a) and 15(b). Enter amount. 15(c)

16. Amount due. If the amount in item 14(a) or 14(d) is LARGER than the amount in item 15(c), subtract item 15(c) from item 14(a) or 14(d) and enter the amount due in item 16

See page 31 of instructions for payment methods. Indicate how you are paying the amount due:

by check enclosed with this form, or by electronic payment.

17. Overpayment. If the amount in item 14(a) or 14(d) is SMALLER than the amount in item 15(c), subtract item 14(a) or 14(d) from item 15(c) and enter the overpayment in item 17

An amount of overpayment may be refunded or credited against the plan's next premium filing.

If you want to take a credit, check here: If you want a refund, check here:

For a refund by electronic funds transfer, indicate whether transfer is to a checking account or savings account and

enter the bank routing number and account number for the refund and sub-account number (if any)

18. If you have attachments other than Schedule A, check here: Put EIN/PN (item 3(a) and (b)) and date premium payment year commenced (PYC) on each sheet.

19. Multiemployer Plan Declaration (NOTE: SINGLE-EMPLOYER Plan Administrators must sign the certification in item 8 of Schedule A.)

I certify under penalty of perjury that, to the best of my knowledge and belief, the information in this filing is true, correct, and complete.

Signature of Multiemployer Plan Administrator

MM DD YYYY Date

Print or type first name of individual who signs Print or type last name of individual who signs Business E-mail Address (Optional)