PBGC Form 1-ES
Pension Benefit Guaranty Corporation
2006

Estimated Premium Payment

(Plans with 500 or more Participants in prior filing year)
For Plan Years Beginning in Calendar Year 2006

Check for Amended Filing [X] Check for Disaster Relief [X] (see instructions)

Approved OMB 1212-0009
PB0648 990406
Photocopies and downloaded forms may be filed (see instructions).

1. Plan Sponsor Check for name/address change [ ]
Check if you do not want instructions next year [X]

Name: Thomas Chan
Address Line 1: 123 New Road
Address Line 2: Suite 100
City: White Plains State: MD Zip: 20601

2. Plan Administrator Check for name/address change [ ]
Check if same as sponsor and go to Item 3 [ ]

Name: Grace Lighthouse
Address Line 1: 555 Paper Rd.
Address Line 2: Suite 77
City: Little Rock State: TX Zip: 33333

3. Employer Identification Number/Plan Number (EIN/PN), Electronic Filing
(a) Enter 9-digit EIN: 88-8888888
(b) Enter 3-digit PN: 888

(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 [X] 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, page 8.)

Transferor's 9-digit EIN	3-digit PN	M M D D Y Y Y Y	Transfer Type M	C	S
12-1111111	111	08-13-2005	X		

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

(d) If this form is filed after electronic filing is mandatory, did PBGC grant the plan an exemption from required electronic filing? [ ] Yes [ ] No, attach explanation

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
77-7777777	777	01-01-2005

5. Plan Information
(a) Plan Name: Single Employer Estimated Sample
(b) Plan Year Beginning (M M D D Y Y Y Y): 01-01 2006
(c) Plan Year Ending (M M D D Y Y Y Y): 12-31-2006

6. Estimated premium for this plan

		Estimated Participant Count		
(a) Single-Employer	$30.00 X	500	=	$ 15,000.00
(b) Multiemployer	$ 8.00 X		=	$

7. Premium credit balance (overpayment) from previous years or other credit
(including estimated short-year credit) (See instructions, pages 9-10.) $ 1,000.00

8. Amount Due
(a) Enter premium payment due (item 6 minus item 7) and submit payment to PBGC. $ 14,000.00
(b) Payment method (Check appropriate box to indicate the method for payment to PBGC.)
[ ] Check enclosed with this form [ ] Electronic Payment (see instructions)

I certify under penalty of perjury that, to the best of my knowledge and belief, the information in items 1-5 and 7 of this form is true, correct and complete.

Signature of Plan Administrator
Date (M M D D Y Y Y Y): 02-17-2006
Telephone Number (include Area Code)

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