

Hurricane Katrina

Annual Premium Payment for
Single—Employer Plans Exempt
from the Variable—Rate Premium

For Plan Years Beginning in Calendar Year 2006

Check for Amended Filing Check for Disaster Relief (see instructions)
See the 2006 Premium Payment Package for the instructions for Form 1-EZ

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

1. Plan Sponsor Check for name/address change <input type="checkbox"/> Check if you do not want instructions next year <input checked="" type="checkbox"/>		2. Plan Administrator Check for name/address change <input type="checkbox"/> Check if same as plan sponsor and go to Item 3 <input type="checkbox"/>	
Name: Matt Kingsman		Name: Judith Foxx	
Address Line 1: 888 Parkway Ave		Address Line 1: 222 Conventry Way	
Address Line 2: Suite 6		Address Line 2: Brownfield	
City: Arlington	State: VA	City: Brownfield	State: IL
Zip: 22222	Zip: 22222	City: Brownfield	State: IL
City: Arlington	State: VA	City: Brownfield	State: IL
Zip: 22222	Zip: 22222	City: Brownfield	State: IL

3. Employer Identification Number/Plan Number (EIN/PN), Electronic Filing

(a) Enter 9-digit EIN: **44-4444444** (b) Enter 3-digit PN: **444**

(c) Does EIN/PN match entry on 2005 Form 5500? Yes No 2005 Form 5500 not required.
If no, attach explanation, check box in item 19, and enter EIN/PN from 2005 Form 5500: 9-digit EIN 3-digit PN

(d) If the plan had 500 or more participants for the prior plan year and this form is filed after electronic filing is mandatory, did PBGC grant the plan an exemption from required electronic filing for this premium filing? Yes No, attach explanation and check box in item 19.

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.

(a) Prior 9-digit EIN: **12-1212121** (b) Prior 3-digit PN: **121** (c) Effective Date of Change: **01-01-2006**

5. Plan Coverage Status (check one) (a) Covered (b) Uncertain (If uncertain, you should file. See instructions, page 20.)

6. Is this the first year's premium filing for this plan? No Yes If yes, enter the following dates.

(a) Plan effective date: **08-13-2005** (b) Plan adoption date: **08-13-2005** (c) Plan coverage date: **08-13-2005**

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? (See instructions, page 21.)
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).

Transferor's 9-digit EIN: **22-3222223** 3-digit PN: **111** M M D D Y Y Y Y: **11-01-2005** Transfer Type: M C S

(If more than 1, attach a separate sheet that lists the additional EIN/PNs, dates, and transfer types, and check the box in item 19.)

8. Business Code and CUSIP number

(a) Enter 6-digit Business Code: **334334** (b) Enter first 6 digits of CUSIP number: **123456**

9. Name of Plan: **EZ No Actuary Sign**

10. Name and Phone Number of Plan Contact

(a) Name: **Bill Parson** (b) Area Code and Phone Number: **444-444-4444**

11. (a) This premium is for the plan year beginning: **01-01 2006** (b) This premium is for the plan year ending: **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: **1/1/2006**

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

9-digit EIN

44-4444444

3-digit F

14

12. Variable-Rate Premium Exemption Category: Check a single box.
- (a) No Vested Participants. (b) 412 (i) Plan. (c) Fully funded plan with fewer than 500 Participants.

(d) Standard Termination with a proposed termination date (on or before the snapshot date) of: M M D D Y Y Y Y

(e) Plan at Full Funding Limit.

13. Enter PARTICIPANT COUNT for the plan year specified in item 11. 13

(See instructions, page 24.)

14. PREMIUM: Multiply the participant count in item 13 by 30. 14

15. Premium credits (See instructions, page 24.)

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

(b) Other credit (including any credit claimed on the 2006 estimated filing and any short-year credit). (See instructions, page 24.) 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 is LARGER than the amount in item 15(c), subtract item 15(c) from item 14 and enter the amount due in item 16. 16

See page 25 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 is SMALLER than the amount in item 15(c), subtract item 14 from item 15(c) and enter the overpayment in item 17. 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. Participant Notice Requirement

For the 2005 plan year, a Participant Notice under ERISA section 4011 and 29 CFR Part 4011:

- (1) Was not required to be issued; or (2) Was issued on time and in accordance with all other applicable requirements; or

(3) An explanation is attached.

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

20. Certification of Plan Administrator. I certify under penalty of perjury that, to the best of my knowledge and belief, this Form 1-EZ (including attachments) is true, correct, and complete.

Signature of Single-Employer Plan Administrator

Date

Print or type first name of individual who signs Print or type last name of individual who signs

Business E-mail Address (Optional)

21. Certification of Enrolled Actuary. An Enrolled Actuary must sign and complete the certification below if box 12 (c) or 12 (e) is checked.

I certify under penalty of perjury that, to the best of my knowledge and belief, the plan qualifies for the exemption checked in item 12.

Enrollment Number

Signature of Enrolled Actuary

Date

Print or type first name of individual who signs Print or type last name of individual who signs

Telephone Number or E-mail (Optional)

Street Address

City

State

Zip Code