



Estimated Premium Payment
 (Plans with 500 or more Participants in prior filing year)
 For Plan Years Beginning in Calendar Year 2005



Check for Amended Filing Check for Disaster Relief (see instructions)

<p>1. Plan Sponsor Check for name/address change <input type="checkbox"/></p> <p>Check if you do not want forms and instructions next year <input type="checkbox"/></p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p>	<p>2. Plan Administrator Check for name/address change <input type="checkbox"/></p> <p>Check if same as plan sponsor and go to Item 3 <input type="checkbox"/></p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p>
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3. Employer Identification Number/ Plan Number (EIN/PN) (a) Enter 9-digit EIN (b) Enter 3-digit PN

(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 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

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

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

5. Plan Information

(a) Plan Name

(b) Plan Year Beginning	M M D D Y Y Y Y 2005	(c) Plan Year Ending
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6. Estimated premium for this plan Estimated Participant Count

(a) Single-Employer	\$19.00	X		=	\$	
(b) Multiemployer	\$ 2.60	X		=	\$	

7. Premium credit balance (overpayment) from previous years or other credit
 (including estimated short-year credit) (See instructions, pages 8-9.) \$

8. Amount Due

(a) Enter premium payment due (item 6 minus item 7) and submit payment to PBGC. \$

(b) Payment method (Check appropriate box to indicate the method for payment to PBGC.)

Check Electronic Funds Transfer (See instructions.)

	M M D D Y Y Y Y	
Signature of Plan Administrator	Date	Telephone Number (include Area Code)
Print or type first name of individual who signs	Print or type last name of individual who signs	Business E-mail Address (Optional)