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 ☐   Check for Disaster Relief ☐   (see instructions)

✛

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

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1. Plan Sponsor   Check for name/address change ☐

Check if you do not want ☐
instructions next year

Name

Address Line 1

Address Line 2

City   State   Zip

2. Plan Administrator   Check for name/address change ☐

Check if same as sponsor and go to Item 3 ☐

Name

Address Line 1

Address Line 2

City   State   Zip

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

(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

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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
[ ]   [ ]   [ ]

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5. Plan Information

(a) Plan Name [ ]

                              M M   D D   Y Y Y Y   M M   D D   Y Y Y Y
(b) Plan Year Beginning [**2 0 0 6**   ]   (c) Plan Year Ending [   ]

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6. Estimated premium for this plan   Estimated Participant Count

(a) Single-Employer $30.00   X   [ ]   = $ [ ]

(b) Multiemployer $ 8.00   X   [ ]   = $ [ ]

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7. Premium credit balance (overpayment) from previous years or other credit

(including estimated short-year credit) (See instructions, pages 9-10.) $ [ ]

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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 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.

✛

                                          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)