

**CONFIDENTIAL EMPLOYER INFORMATION**

Name of Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Approximate number of full time employees: \_\_\_\_\_

Entity:  "C" Corporation       LLC taxed as Corporation       LLC taxed as Partnership  
 Partnership       Sole Proprietor       "S" Corporation

Date Present Company Established: \_\_\_\_\_ Fiscal Year End: \_\_\_\_\_

Predecessor Business name (if any): \_\_\_\_\_

Date Established: \_\_\_\_\_

Entity:  "C" Corporation       LLC taxed as Corporation       LLC taxed as Partnership  
 Partnership       Sole Proprietor       "S" Corporation

Any affiliated or controlled companies:  Yes       No  
If yes, describe ownership and income relationships in "Comment" field.

Nature of Business: \_\_\_\_\_

Are any employees subject to collective bargaining? \_\_\_\_\_

How much of a tax deduction do you want? \$ \_\_\_\_\_

Any Existing Plan?  Yes       No  
If yes, describe in "Comment" field.

**Company Officers:**

Name	Position	% of Ownership	Check if Trustee

**List employees you want to benefit most:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Comment:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Pension & Financial Services Inc.**

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◆ Fax (516) 228-8457  
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CONFIDENTIAL EMPLOYEE DATA

**Please Complete All Columns - List All Employees**

EMPLOYER

DATE COMPILED

ADDRESS

COMPENSATION FOR 12 MONTHS ENDING

/ /

LAST NAME, FIRST NAME PERSON TO CONTACT	SEX F-M	DATE OF BIRTH			DATE EMPLOYED			HOURS WORKED THIS PLAN YEAR	ANNUAL COMPENSATION	DATE OF TERMINATION		
		MM	DD	YY	MM	DD	YY			MM	DD	YY
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NOTE: If Any Employees listed above are related please indicate relationship in "Comment" field, above.