



**Annual Premium Payment**  
For Plan Years Beginning in Calendar Year 2003

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

Check for Amended Filing  Check for Disaster Relief  (see instructions)  
See the 2003 Premium Payment Package for the Instructions for Form 1

|   |  |
|---|--|
| <p><b>1. Plan Sponsor</b>      Check for address change <input type="checkbox"/></p> <p>Check if you do not want forms and instructions next year <input type="checkbox"/></p> <p>_____<br/>Name</p> <p>_____<br/>Address</p> <p>_____<br/>City                                  State                                  Zip</p> | <p><b>2. Plan Administrator</b>      Check for address change <input type="checkbox"/></p> <p>Check if same as plan sponsor and go to item 3 <input type="checkbox"/></p> <p>_____<br/>Name</p> <p>_____<br/>Address</p> <p>_____<br/>City                                  State                                  Zip</p> |
|---|--|

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

(a) Enter 9-digit EIN       (b) Enter 3-digit PN

(c) Does EIN/PN match entry on 2002 Form 5500?  Yes     No     2002 Form 5500 not required.

If no, attach explanation, check box in item 18, and enter EIN/PN from 2002 Form 5500:    9-digit EIN       3-digit PN

**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                     | (b) Prior 3-digit PN                     | (c) Effective Date of Change              |
| <input style="width:150px;" type="text"/> | <input style="width:80px;" type="text"/> | M M    D D    Y Y Y Y                     |
| <input style="width:150px;" type="text"/> | <input style="width:80px;" type="text"/> | <input style="width:150px;" type="text"/> |

**5. Plan Coverage Status (check one)**    (a)  Covered    (b)  Uncertain (If uncertain, you should file. See instructions, page 25.)

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

|   |   |   |
|---|---|---|
| (a) Plan effective date                   | (b) Plan adoption date                    | (c) Plan coverage date                    |
| M M    D D    Y Y Y Y                     | M M    D D    Y Y Y Y                     | M M    D D    Y Y Y Y                     |
| <input style="width:150px;" type="text"/> | <input style="width:150px;" type="text"/> | <input style="width:150px;" type="text"/> |

**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 25.)     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).

| Transferor's 9-digit EIN                  | 3-digit PN                               | M M    D D    Y Y Y Y                     | Transfer Type            |                          |                          |
|---|--|---|--------------------------|--------------------------|--------------------------|
| <input style="width:150px;" type="text"/> | <input style="width:80px;" type="text"/> | <input style="width:150px;" type="text"/> | M                        | C                        | S                        |
| <input style="width:150px;" type="text"/> | <input style="width:80px;" type="text"/> | <input style="width:150px;" type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input style="width:150px;" type="text"/> | <input style="width:80px;" type="text"/> | <input style="width:150px;" type="text"/> | M                        | C                        | S                        |
| <input style="width:150px;" type="text"/> | <input style="width:80px;" type="text"/> | <input style="width:150px;" type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

(If more than 2, attach a separate sheet that lists the additional EIN/PNs, dates, and transfer types, and check the box in item 18.)

**8. Enter 6-digit Business Code:**

**9. Name of Plan:**





768592

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

[Empty box for 9-digit EIN]

[Empty box for 3-digit PN]

10. Name and Phone Number of Plan Contact

(a) Name: [Empty box]

(b) Area Code and Phone Number [Empty box]

11. Plan Type (Check appropriate box to indicate type of plan and type of filing.)

(a)  Multiemployer plan (b)  Single-Employer plan (Includes Multiple Employer plan)

12. (a) This premium is for the plan year beginning: M M D D Y Y Y Y [2003]

(b) This premium is for the plan year ending: M M D D Y Y Y Y [Empty box]

(c)  Check here if the plan year beginning date has changed since last filing with PBGC

(d) Adoption date of plan year change: M M D D Y Y Y Y [Empty box]

13. Enter PARTICIPANT COUNT for the plan year specified in item 12.

(See instructions, page 26.) ..... 13 [Empty box]

14. (a) MULTIEMPLOYER premium: Multiply item 13 by the \$2.60 premium rate and enter amount. 14(a) [Empty box]
(b) SINGLE-EMPLOYER flat rate premium: Multiply the participant count in item 13 by \$19. 14(b) [Empty box]
(c) SINGLE-EMPLOYER variable rate premium: From Schedule A, item 5. 14(c) [Empty box]
(d) SINGLE-EMPLOYER total premium: Add items 14(b) and 14(c). Enter amount. 14(d) [Empty box]

15. Premium credits (See instructions, page 27.)
(a) Amount paid by check or electronic funds transfer with 2003 Form 1-ES (item 8 of Form 1-ES). 15(a) [Empty box]
(b) Other credit (including any credit claimed in item 7 of the 2003 Form 1-ES and any short-year credit). (See instructions, page 27.). 15(b) [Empty box]
(c) Total credit: Add items 15(a) and 15(b). Enter amount. 15(c) [Empty box]

16. Amount due. If the amount in item 14(a) or 14(d) is LARGER than the amount in item 15(c), subtract item 15(c) from item 14(a) or 14(d) and enter the amount due in item 16. 16 [Empty box]
See page 27 of instructions for payment methods. Indicate how you are paying the amount due:
 by check enclosed with this form, or  by electronic funds transfer.

17. Overpayment. If the amount in item 14(a) or 14(d) is SMALLER than the amount in item 15(c), subtract item 14(a) or 14(d) from item 15(c) and enter the overpayment in item 17. 17 [Empty box]
See page 28 of instructions for application of overpayments. An amount of overpayment not otherwise applied may be refunded or credited against the plan's next premium filing. If you want a refund, check here: 
For refund by electronic funds transfer, indicate whether transfer is to a checking account  or savings account  and enter the bank routing number [Empty box] and account number for the refund [Empty box] and sub-account number (if any) [Empty box]

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

19. Multiemployer Plan Declaration (NOTE: SINGLE-EMPLOYER Plan Administrators must sign the certification in item 6 of Schedule A.)

Under penalties of perjury (18 U.S.C. 1001), I declare that I have examined this filing, and to the best of my knowledge and belief it is true, correct and complete.

[Empty box for Signature of Multiemployer Plan Administrator]

[Empty box for Print or type first name of individual who signs]

M M D D Y Y Y Y [Empty box for Date]

[Empty box for Business E-mail Address (Optional)]

