

National Compensation Survey

Employment Cost Index

Month Year Update

Schedule # - 999999

{Index benefits summary only – Private industry}

Thank you for your assistance with the Employment Cost Index. Your summary of benefits report is enclosed. **Please update the plan information and costs within one week of receiving this package.** Include any scheduled changes effective before the reference date of MONTH 12, YEAR. If there are significant changes, we may need to follow up with you to get more details.

There are several reporting options available:

- Secure file transfer over the internet – <https://www.BLSCompdata.bls.gov>
- Email to BLSCompdata@bls.gov
- Fax the completed form to 999-999-9999
- Mail a printed report or the completed form

Data can be reported in any standard format, but be sure to include your schedule number, 999999, on any reports or emails.

If you have any questions, please contact: XXXX XXXXXXX at 999-999-8888.

Please correct name, title, or address, as needed.

Prepared by:

Name _____

Title _____

Telephone: _____

Date Prepared: _____

Respondent Name

Respondent Title

Company Name

Company Name 2

Address1

Address2

City, State Zip

As entered by the regional office

As a participant in a Bureau of Labor Statistics (BLS) statistical survey, you should be aware that use of electronic transmittal methods in reporting data to the BLS involves certain inherent risks to the confidentiality of those data. Further, you should be aware that responsible electronic transmittal practices employed by the BLS cannot completely eliminate those risks.

The BLS is committed to the responsible treatment of the data you report and will take appropriate steps within its ability to protect the confidentiality of those data.

The Bureau of Labor Statistics, its employees, agents, and partner statistical agencies, will use the information you provide for statistical purposes only and will hold the information in confidence to the full extent permitted by law. In accordance with the Confidential Information Protection and Statistical Efficiency Act of 2002 (Title 5 of Public Law 107-347) and other applicable Federal laws, your responses will not be disclosed in identifiable form without your informed consent.

This report is authorized by law, 29 U.S.C. 2. Your voluntary cooperation is needed to make the results of this survey comprehensive, accurate and timely.

**Form Approved
O.M.B. #1220-0164
Expires 12/31/10**

We estimate that it will take an average of 19 minutes to complete this form, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing this information. If you have any comments regarding this estimate or any other aspect of this survey; including suggestions for reducing this burden, please send them to the Bureau of Labor Statistics, Office of Compensation and Working Conditions (1220-0164), 2 Massachusetts Avenue N.E., Washington, D.C. 20212. You are not required to respond to the collection of information unless it displays a currently valid OMB control number.

(NOTE: This is a computer-generated form that provides prior benefits data to, and requests updated benefits data from survey respondents)

Summary of Benefits example – update

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Establishment = Any Company Schedule Number = XXXXXXXX

Mr. Xxxx Xxxxx, CEO
(TEL.) Number

Ben #	Plan description	Expected to change
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BENEFIT DESCRIPTIONS COVER THE FOLLOWING OCCUPATIONS

XXXX Division Manager

XXXX Head Technician

XXXX Secretary

XXXX Janitor

01 WORK SCHEDULE – Full-time and part-time
Full-time 8.00 hours/day 40.00/weekly hours 52.0 annual weeks

Part-time 5.00 hours/day 25.00/weekly hours 52.0 annual weeks

**01 1.5X after 40 hours/wk,
2.0X on Sundays**

02 VACATION
After 6 months = 1 week
After 1 year = 2 weeks
After 5 years = 3 weeks
After 10 years = 4 weeks (max.)

**Total cost: Single =
\$212.34/month
Family =
\$458.16/month**

12

SHORT TERM DISABILITY INSURANCE

Optional plan. 100% employee paid.

10/01/08

Summary of Benefits example – update

U. S. DEPARTMENT OF LABOR BUREAU OF LABOR STATISTICS

Establishment = Any Company Schedule Number = XXXXX

BEN #	PLAN DISCRPTION	EXPECTED TO CHANGE
23	<p>PLEASE PROVIDE 2007 RATE <u>LONG TERM DISABILITY PAY</u> Full-time: Benefit = 60% of salary up to \$4,000/month until retirement age. 2007 TOTAL COST = \$.70/\$100 of payroll Company pays 50% Employee pays 50%</p>	03/01/08
13	<p><u>DEFINED BENEFIT PENSION PLANS</u> Pension plan: Pays 2.0%X years of service 2007 Fiscal Year: Co. Cost = \$ 189,359.00 Co. gross payroll = \$2,310,922.00 Eligibility: Must work over 1,000 hrs/year.</p>	
20	<p>PLEASE PROVIDE 2004RATE. <u>STATE UNEMPLOYMENT INSURANCE</u> 2007 rate = 2.4%</p>	03/01/08
21	<p><u>WORKER'S COMPENSATION</u> 2007 Rates Office 8810 = \$.27/\$100.00 Sales workers 8742 = \$.89/\$100.00 Experience Modifier = 1.15 Premium Discount = 9.0%</p>	06/01/08
22	<p><u>THERE ARE NO PROVISIONS FOR THE FOLLOWING BENEFITS:</u> Defined Contribution Plan</p>	