U.S. Department of Labor
Bureau of Labor Statistics

National Compensation Survey

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We estimate that it will take an average of 177 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.

BENEFITS COLLECTION FORM FOR PRIVATE INDUSTRY

Establishment: _____ Schedule #: _____

EIN: _____ Field Economist: _____ Date Collected: _____

Status	Est.	Quotes								
		All	1	2	3	4	5	6	7	8
☐ Usable										
☐ On strike										
☐ Temporary non-response										
☐ Refusal (Explain)										
☐ No matching jobs										

Explain: _____

Benefit	Estab.		Quotes (Indicate NP or RE)							
	NP*	RE*	1	2	3	4	5	6	7	8
Overtime (Premium pay)										
Vacations										
Holidays										
Sick leave										
Other leave										
Shift differentials										
Non-production bonus										
Life insurance										
Health insurance										
Short-term disability										
Long-term disability										
Defined benefit										
Defined contribution										
Social Security										
Medicare										
Federal Unemployment Tax Act										
State unemployment										
Workers compensation										

***NP=** no plan offered, ***RE=** unknown whether a plan exists

NCS Form 04-5P (September 2007)

Benefit Collection Address/Officials

Sched. # _____

(Fill out this page if different Address/Official contacted from the Wage Address/Officials listed on the "General Establishment Information" section in IDC.)

Benefit Collection Address # 1.

☐ Physical Address ☐ Personal Visit Address ☐ Mailing Address

Company Name:		
Secondary Name (Doing Business As):		
Address:		
City/State/ZIP:		
☐ Authorizing ☐ Supplying →		Name:
Telephone		Title:
Fax		
Email Address		Benefits to be collected here are: #'s___,___,___,___,___,___,___,___,___,___,___,___,___,___,___,___

Benefit Collection Address # 2.

☐ Physical Address ☐ Personal Visit Address ☐ Mailing Address

Company Name:		
Secondary Name (Doing Business As):		
Address:		
City/State/ZIP:		
☐ Authorizing ☐ Supplying →		Name:
Telephone		Title:
Fax		
Email Address		Benefits to be collected here are: #'s___,___,___,___,___,___,___,___,___,___,___,___,___,___,___,___

Benefit Collection Address # 3.

☐ Physical Address ☐ Personal Visit Address ☐ Mailing Address

Company Name:		
Secondary Name (Doing Business As):		
Address:		
City/State/ZIP:		
☐ Authorizing ☐ Supplying→		Name:
Telephone		Title:
Fax		
Email Address		Benefits to be collected here are: #'s___,___,___,___,___,___,___,___,___,___,___,___,___,___,___,___

HEALTH

If no plan is available for matched employees, are health benefit plans offered to any employees?

- ☐ Yes
- ☐ No
- ☐ Not determinable

RETIREE HEALTH INSURANCE

Does the establishment offer health benefits to retirees under 65? (Choose one)

- ☐ No
- ☐ Yes, employer paid
- ☐ Yes, retiree paid
- ☐ Yes, jointly paid
- ☐ Yes, who pays unknown
- ☐ Not determinable

Does the establishment offer health benefits to retirees 65 and over? (Choose one)

- ☐ No
- ☐ Yes, employer paid
- ☐ Yes, retiree paid
- ☐ Yes, jointly paid
- ☐ Yes, who pays unknown
- ☐ Not determinable

DEFINED BENEFITS

If no plan is available for matched employees, are defined benefit plans offered to any employees?

- ☐ Yes
- ☐ No
- ☐ Not determinable

DEFINED CONTRIBUTION

If no plan is available for matched employees, are defined contribution plans offered to any employees?

- ☐ Yes
- ☐ No
- ☐ Not determinable

OVERTIME (PREMIUM PAY, Benefit 01) Sched. # _____

Quotes: _____ Date of expected change (DOEC): _____

Eligibility: _____ Plan name: _____

Quote:	Type, Premium, and Annual Hours					Average Occupational Employment
	Daily after ___ hours	Weekly after ____ hours	Paid Holidays* _____X –1 X	Weekends	Other (specify)	
	Premium: _____	Premium: _____	Premium: _____	Premium: _____	Premium: _____	
	Annual hours per quote	Annual hours per quote	Annual hours per quote	Annual hours per quote	Annual hours per quote	
1						
2						
3						
4						
5						
6						
7						
8						

*for paid holidays subtract out regular holiday pay

Remarks/Calculations:

Payment Basis:

- ☐ Base pay (BP)
- ☐ AVERAGE HOURLY RATE (AHR)
- ☐ AHR + Shift (SD)
- ☐ AHR + Bonus (BN)
- ☐ Other (specify): _____

Time Basis:

- ☐ Regular work schedule
- ☐ Alternate work schedule
- ☐ Other (specify): _____

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

Annual overtime hours: _____

Expenditure:

- ☐ Calendar year _____
- ☐ Fiscal year ending ____/_____/_____

VACATION (Benefit 02) Sched. # _____

Plan # 1 name:_____	**LOS**	**Vacation Plan**
Eligibility: _____		
Quotes: _____		
Vacation schedule:		
☐ Percent of earnings		
☐ Union fund		
☐ Time		
Is this part of a consolidated leave plan?		
☐ Yes ☐ No ☐ ND (NOT DETERMINABLE)		
If yes, check all that apply:		
☐ Vacation ☐ Personal ☐ ND (NOT DETERMINABLE)		
☐ Military ☐ Sick		
☐ Holidays ☐ Family		
☐ Jury Duty ☐ Funeral		

Plan # 2 name:_____	**LOS**	**Vacation Plan**
Eligibility: _____		
Quotes: _____		
Vacation schedule:		
☐ Percent of earnings		
☐ Union fund		
☐ Time		
Is this part of a consolidated leave plan?		
☐ Yes ☐ No ☐ ND (NOT DETERMINABLE)		
If yes, check all that apply:		
☐ Vacation ☐ Personal ☐ ND (NOT DETERMINABLE)		
☐ Military ☐ Sick		
☐ Holidays ☐ Family		
☐ Jury Duty ☐ Funeral		

Payment Basis:

- ☐ Base pay (BP)
- ☐ AVERAGE HOURLY RATE (AHR)
- ☐ AHR + Shift (SD)
- ☐ AHR + Bonus (BN)
- ☐ Other (specify): _____

Time Basis:

- ☐ Regular work schedule
- ☐ Alternate work schedule
- ☐ Other (specify): _____

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

Expenditure:

☐ Calendar year _____

☐ Fiscal year ending ____/_____/_____

VACATION (SUPPLEMENTARY SHEET)

Sched. #_____

Date of expected change (DOEC): _____

Schedule	Quotes							
	1	2	3	4	5	6	7	8
☐ L.O.S. ☐ D.O.H.								
Less 1 month								
1 month								
2 months								
3 months								
4 months								
5 months								
6 months								
7 months								
8 months								
9 months								
10 months								
11 months								
1 year								
2 years								
3 years								
4 years								
5 years								
6 years								
7 years								
8 years								
9 years								
10 years								
11 years								
12 years								
13 years								
14 years								
15 years								
16 years								
17 years								
18 years								
19 years								
20 years								
21 years								
22 years								
23 years								
24 years								
25 years								
26 years								
27 years								
28 years								
29 years								
30 years								
30+ years								
Occupational Employment								

HOLIDAYS (Benefit 03) Sched. #_____

Quotes: _____ Date of expected change (DOEC):_____

Eligibility: _____ Plan name: _____

Holidays	Number of days		Holidays	Number of days	
	Paid	Unpaid		Paid	Unpaid
New Year's Eve	.	.	Veteran's Day	.	.
New Year's Day	.	.	Thanksgiving Day	.	.
Martin Luther King's Birthday	.	.	Day after Thanksgiving	.	.
President's Day	.	.	Christmas Eve	.	.
Good Friday	.	.	Christmas Day	.	.
Memorial Day	.	.	Employee's Birthday	.	.
July 4th	.	.	Floating	.	.
Labor Day	.	.	Other (specify):	.	.
Columbus Day	.	.	**Total days**	.	.
Election Day	.	.			

Remarks/Calculations:

Payment Basis:

- ☐ Base pay (BP)
- ☐ AVERAGE HOURLY RATE (AHR)
- ☐ AHR + Shift (SD)
- ☐ AHR + Bonus (BN)
- ☐ Other (specify): _____

Time Basis:

- ☐ Regular work schedule
- ☐ Alternate work schedule
- ☐ Other (specify): _____

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

Expenditure:

- ☐ Calendar year _____
- ☐ Fiscal year ending ____/_____/_____

SICK LEAVE (Benefit 04) Sched. #_____

Quotes: _____ Date of expected change (DOEC): _____

Eligibility: _____ Plan name: _____

Sick leave plan:

__ Max. days per year
__ Other (specify)
__ Not determinable

Schedule	Paid Days at 100%	Unpaid Days

Waiting Period: ☐ Yes ☐ No Number of Days for waiting period _____

Unlimited days: ☐ Yes ☐ No

Informal plan: ☐ Yes ☐ No

Leave Usage (days) Worksheet:

Cash-in: ☐ Yes ☐ No

Carry over: ☐ Yes ☐ No Maximum Days _____

Informal plan: ☐ Yes ☐ No

Remarks/Calculations:

Payment Basis:

- ☐ Base pay (BP)
- ☐ AVERAGE HOURLY RATE (AHR)
- ☐ AHR + Shift (SD)
- ☐ AHR + Bonus (BN)
- ☐ Other (specify): _____

Time Basis:

- ☐ Regular work schedule
- ☐ Alternate work schedule
- ☐ Other (specify): _____

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

_____/_____/_____

Expenditure:

☐ Calendar year _____

☐ Fiscal year ending

OTHER LEAVE (Benefit 05)

Sched. #_____

Date of expected change (DOEC): _____

Leave Plan	Quotes Covered	Eligibility	Paid Days	Payment Rate	Unpaid Days
Funeral Leave					
Jury Duty Leave					
Military Leave					
Family Leave					
Personal Leave					
Other (specify) Paid Leave					
Leave Without Pay					

Leave Usage (days) Worksheet:

Cash-in: ☐ Yes ☐ No

Carry over: ☐ Yes ☐ No Maximum Days _____

Informal plan: ☐ Yes ☐ No

Quote	Personal		Funeral		Military		Jury Duty		Family		Other		Occ. Employ.
	Paid	Unpaid	Paid	Unpaid	Paid	Unpaid	Paid	Unpaid	Paid	Unpaid	Paid	Unpaid	
1													
2													
3													
4													
5													
6													
7													
8													

Remarks/Calculations:

Payment Basis:

- ☐ Base pay (BP)
- ☐ AVERAGE HOURLY RATE (AHR)
- ☐ AHR + Shift (SD)
- ☐ AHR + Bonus (BN)
- ☐ Other (specify): _____

Time Basis:

- ☐ Regular work schedule
- ☐ Alternate work schedule
- ☐ Other (specify): _____

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

_____/_____/_____

Expenditure:

- ☐ Calendar year _____
- ☐ Fiscal year ending

SHIFT DIFFERENTIAL (Benefit 06)

Sched. #_____

Quotes: _____

Date of expected change (DOEC): _____

Eligibility: _____

Plan name: _____

Quote	Total EE*	1st Shift EE*	2nd shift					3rd shift					Other: _____				
			2nd EE*	$*	%*	Hrs Pd	Hrs Wk	3rd EE	$	%	Hrs Pd	Hrs Wk	Other EE	$*	%*	Hrs Pd*	Hrs Wk*
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	

*Total EE= total employment of quote; *1st Shift EE= first shift employment; *$= cents or dollars per hour of differential; *%= percent extra paid for shift differential over straight time rate; *Hrs Pd= hours paid per shift; *Hrs Wk= hours worked per shift

Remarks/Calculations:

Payment Basis:

- ☐ Base pay (BP)
- ☐ AVERAGE HOURLY RATE (AHR)
- ☐ AHR + Shift (SD)
- ☐ AHR + Bonus (BN)
- ☐ Other (specify): _____

Time Basis:

- ☐ Regular work schedule
- ☐ Alternate work schedule
- ☐ Other (specify): _____

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

Expenditure:

☐ Calendar year _____

☐ Fiscal year ending ____/_____/_____

NONPRODUCTION BONUS (Benefit 07)

Sched. #_____

Quotes: _____ Date of expected change (DOEC): _____

Eligibility: _____ Plan name: _____

✔	Plan Type	Provisions/Benefit Formula
	Attendance	
	Cash profit sharing	
	Employee recognition program	
	End-of-year discretionary bonus	
	Hiring	
	In-lieu of benefit payment	
	Referral	
	Retention	
	Safety	
	Signing	
	Suggestion	
	Union-related	
	Other (specify)	
	Not determinable	

Usage/Cost:

Payment Basis:

- ☐ Base pay (BP)
- ☐ AVERAGE HOURLY RATE (AHR)
- ☐ AHR + Shift (SD)
- ☐ AHR + Bonus (BN)
- ☐ Other (specify): _____

Time Basis:

- ☐ Regular work schedule
- ☐ Alternate work schedule
- ☐ Other (specify): _____

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

Expenditure:

- ☐ Calendar year _____
- ☐ Fiscal year ending ____/_____/_____

LIFE INSURANCE (Benefit 10)

Sched. #_____

Quotes: _____ Date of expected change (DOEC): _____

Eligibility: _____ Plan name: _____

Plan No.	Name	Type
01		
02		
03		

Remarks/Calculations:

Payment Basis:

- ☐ Base pay (BP)
- ☐ AVERAGE HOURLY RATE (AHR)
- ☐ AHR + Shift (SD)
- ☐ AHR + Bonus (BN)
- ☐ Other (specify): _____

Time Basis:

- ☐ Regular work schedule
- ☐ Alternate work schedule
- ☐ Other (specify): _____

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

Expenditure:

- ☐ Calendar year _____
- ☐ Fiscal year ending ____/_____/_____

LIFE INSURANCE (Benefit 10)

Sched. #_____

Type:

Plan no.	Eligibility
01	
02	
03	

Formula: (Choose one formula and answer columns accordingly.)

Plan no.	Multiple of earnings		Max. benefit amount. Enter $, No, or ND*	Flat Amount		Other (✔)	ND* (✔)
	Varies (✔)	Fixed (Enter multiple)		Varies (✔)	Fixed (Enter $)		
01							
02							
03							

***ND= Not determinable**

Financing: (Choose one financing type and answer columns accordingly.)

Plan no.	Commercially Insured		Self-insured (✔)	Union Health/Welfare
	Enter: Carrier	Enter: Plan Year		Date of expected change (DOEC)
01				
02				
03				

Premiums: (Enter $ amount, No cost, Not determinable)

Plan no.	Company (ER) Cost	Employee (EE) Cost	Total Cost	Earnings Ceiling
01				
02				
03				

Participation (Needed if collection by Rate and Usage)

Plan no.	Quotes															
	1R	1P	2R	2P	3R	3P	4R	4P	5R	5P	6R	6P	7R	7P	8R	8P
01																
02																
03																

R= Participation (# employees in quote taking plan); P= potential participants (total # employees in quote)

Sched. #_____

							Pay after services rendered (1)	Restrictions choice of providers (2)	Outside network higher cost (3)
08									
09									
10									

M= Medical; D= Dental; V= Vision; P= Prescription drugs

1. Does this plan pay benefits after services are rendered, typically after coinsurance and deductibles? *(Answer 2 and not 3 when Yes (Y) is checked. Answer 3 and not 2 when No (N) is checked.)*
2. Are there any restrictions on the choice of plan providers (e.g., network or list of preferred providers)?
3. Can the enrollee go outside the network of plan providers for coverage at higher cost?

Basic Information:

Plan No.	EIN (Employer Identification #)	PN (Plan #)	SPD*(Y/N)	SPD* Date	Master Schedule
01					
02					
03					
04					
05					
06					
07					
08					
09					
10					

*SPD= Summary Plan Description are required at initiation for all health plans.

HEALTH INSURANCE (Benefit 11) Sched. # _____

Financing: (Choose one financing type and answer columns accordingly.)

Plan no.	Commercially Insured		Self-insured (✔) answer 1. and 2.	1. Use of third-party administrators (Y/N)	Union Health/Welfare (Enter date)	2. Use of insurance for claims that exceed certain limits (stop-loss)
	Carrier	Plan Year			Expected change	
01						
02						
03						
04						
05						
06						
07						
08						
09						
10						

Cost: Plan No. _____ (Enter $ amount, No cost, Not determinable)

Premiums	Company (ER) Cost	Employee (EE) Cost	Conversion Code	Total Cost
Single				
Family				
EMP. + Spouse				
EMP. + Child				
EMP. + 1				
EMP. + 2				
EMP. + 3				
EMP. + 4				
OTHER:_____				

Participation: Plan No. _____ (Enter % of quote employment, Not determinable, Not applicable)

	Quotes							
	1	2	3	4	5	6	7	8
Single								
Family								
EMP. + Spouse								
EMP. + Child								
EMP. + 1								
EMP. + 2								
EMP. + 3								
EMP. + 4								
Total participation								

HEALTH INSURANCE (Benefit 11) Sched. # _____

Quotes: _____ Date of expected change (DOEC): _____

Eligibility: _____ Plan name: _____

Remarks/Calculations:

Payment Basis:

- ☐ Base pay (BP)
- ☐ AVERAGE HOURLY RATE (AHR)
- ☐ AHR + Shift (SD)
- ☐ AHR + Bonus (BN)
- ☐ Other (specify): _____

Time Basis:

- ☐ Regular work schedule
- ☐ Alternate work schedule
- ☐ Other (specify): _____

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

Expenditure:

- ☐ Calendar year _____
- ☐ Fiscal year ending ____/_____/_____

SHORT-TERM DISABILITY (Benefit 12)

Sched. # _____

Waiting Period: ☐ Yes ☐ No Number of Days of waiting period _____

Duration: ☐ Fixed # weeks _____ ☐ Number of weeks varies

Formula: (Choose one formula and answer columns accordingly.)

Plan no.	Percent of earnings (✔)		Max. benefit per week. Enter $, No, or ND*	Flat Amount		Other (✔)	ND* (✔)
	Varies (✔)	Fixed (Enter %)		Varies (✔)	Fixed (Enter $)		
01							
02							
03							

*ND= not determinable

Financing: (Choose one financing type and answer columns accordingly.)

Plan no.	Commercially Insured		Self-insured (✔)	Union Health/Welfare Date of expected change (DOEC)	Unfunded (Write details in remarks)	State (✔)	Other (✔)	ND* (✔)
	Enter: Carrier	Enter: Plan Year						
01								
02								
03								

*ND= not determinable

Premiums: (Enter $ amount, No cost, Not determinable)

Plan no.	Company (ER) Cost	Employee (EE) Cost	Total Cost	Earnings Ceiling
01				
02				
03				

Participation: (Enter % of quote employment, Not determinable, Not applicable)

Plan no.	Quotes								
	ALL	1	2	3	4	5	6	7	8
01									
02									
03									

SHORT-TERM DISABILITY (Benefit 12) Sched. # _____

Quotes: _____ Date of expected change (DOEC): _____

Eligibility: _____ Plan name: _____

Remarks/Calculations:

Payment Basis:

- ☐ Base pay (BP)
- ☐ AVERAGE HOURLY RATE (AHR)
- ☐ AHR + Shift (SD)
- ☐ AHR + Bonus (BN)
- ☐ Other (specify): _____

Time Basis:

- ☐ Regular work schedule
- ☐ Alternate work schedule
- ☐ Other (specify): _____

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

_____/_____/_____

Expenditure:

- ☐ Calendar year _____
- ☐ Fiscal year ending

LONG-TERM DISABILITY (Benefit 23)

Sched. # _____

Waiting Period: ☐ Yes ☐ No Number of Days _____

Formula:

Plan no.	Percent of earnings (✔)		If fixed, enter # or ND*	Max. benefit amount. Enter $, No, or ND	Flat Amount (✔)	Other (✔)	ND* (✔)
	Varies	Fixed					
01							
02							
03							

*ND= not determinable

Financing: (Choose one financing type and answer columns accordingly.)

Plan no.	Commercially Insured		Self-insured (✔)	Union Health/Welfare
	Enter: Carrier	Enter: Plan Year		Date of expected change (DOEC)
01				
02				
03				

Premiums: (Enter $ amount, No cost, Not determinable)

Plan no.	Company (ER) Cost	Employee (EE) Cost	Total Cost	Earnings Ceiling
01				
02				
03				

Participation: (Enter % of quote employment, Not determinable, Not applicable)

Plan no.	Quotes								
	ALL	1	2	3	4	5	6	7	8
01									
02									
03									

LONG-TERM DISABILITY (Benefit 23)

Sched. # _____

Quotes: _____

Date of expected change (DOEC): _____

Eligibility: _____

Plan name: _____

Remarks/Calculations:

Payment Basis:

- ☐ Base pay (BP)
- ☐ AVERAGE HOURLY RATE (AHR)
- ☐ AHR + Shift (SD)
- ☐ AHR + Bonus (BN)
- ☐ Other (specify): _____

Time Basis:

- ☐ Regular work schedule
- ☐ Alternate work schedule
- ☐ Other (specify): _____

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

Expenditure:

- ☐ Calendar year _____
- ☐ Fiscal year ending ____/_____/_____

DEFINED BENEFIT PLANS (Benefit 13) Sched. _____

Basic Information:

Plan No.	Plan Name/Carrier	Eligibility	EIN (Employer identification #)	PN (Plan #)	SPD* (Y/N)	SPD* Date	Master Schedule
01							
02							
03							

*SPD= Summary Plan Description are required at initiation for all defined benefit plans.

Provisions:

	Employee required contributions						Other attributes		
Plan no.	None (✔)	Percent of earnings		Coordinated with Social Security (✔)	Other (✔)	ND* (✔)	Ad hoc In last 5 yrs. (✔)	If Ad hoc, enter year	COLA* (✔)
		Enter %	% ND*						
01									
02									
03									

COLA= Cost of living adjustment; *ND= not determinable

Financing: (Not necessary to code)

Plan no.	Commercially Insured		Union Fund
	Enter: Carrier	Enter: Plan Year	Date of expected change (DOEC)
01			
02			
03			

Premiums: (Enter $ amount, No cost, Not determinable)

Plan no.	Company (ER) Cost	Employee (EE) Cost	Total Cost
01			
02			
03			

Participation: (Enter % of quote employment, Not determinable, Not applicable)

Plan no.	Quotes								
	ALL	1	2	3	4	5	6	7	8
01									
02									
03									

DEFINED BENEFIT (Benefit 13) Sched. # _____

Quotes: _____ Date of expected change (DOEC): _____

Eligibility: _____ Plan name: _____

Remarks/Calculations:

Payment Basis:

- ☐ Base pay (BP)
- ☐ AVERAGE HOURLY RATE (AHR)
- ☐ AHR + Shift (SD)
- ☐ AHR + Bonus (BN)
- ☐ Other (specify): _____

Time Basis:

- ☐ Regular work schedule
- ☐ Alternate work schedule
- ☐ Other (specify): _____

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

Expenditure:

- ☐ Calendar year _____
- ☐ Fiscal year ending ____/_____/_____

PBGC

☐ Annual per employee cost: _____ ☐ Annual Expenditure: _____

DEFINED CONTRIBUTION (Benefit 14), UNDUPLICATED TOTALS Sched. #_____

Basic Information:

Plan No.	Plan Name/Carrier	Eligibility	EIN (Employer identification #)	PN (Plan #)	SPD* (Y/N)	SPD* Date	Master Schedule
01							
02							
03							
04							

*SPD= Summary Plan Description are required at initiation for all defined contribution plans.

Provisions:

Plan no.	Type*	Required Employee contribution (✔)	Contributions tax-deferred?
01			
02			
03			
04			

* Deferred Profit Sharing, ESOP, Money Purchase Plan, Savings & Thrift, SEP, SIMPLE, Stock bonus, Other (specify), or Not Determinable

Participation: (Enter % of quote employment, Not determinable, Not applicable)

Plan no.	Quotes								
	ALL	1	2	3	4	5	6	7	8
01									
02									
03									
04									

Unduplicated Totals:

Collect the percentage of employment in DC-only, DB-only, and both DC and DB data, if both the DB and DC plan participation, is between 0 and 100 percent. If the plan participation in either benefit is 0 or 100 percent, the system will compute the unduplicated totals.

Quote	Retirement Percentages		
	% DefinedContribution Only (DC-only)	% Defined Benefit Only (DB-only)	% Both DC and DB
1			
2			
3			
4			
5			
6			
7			
8			

DEFINED CONTRIBUTION (Benefit 14), UNDUPLICATED TOTALS

Sched. # _____

Quotes: _____ Date of expected change (DOEC): _____

Eligibility: _____ Plan name: _____

Remarks/Calculations:

Payment Basis:

- ☐ Base pay (BP)
- ☐ AVERAGE HOURLY RATE (AHR)
- ☐ AHR + Shift (SD)
- ☐ AHR + Bonus (BN)
- ☐ Other (specify): _____

Time Basis:

- ☐ Regular work schedule
- ☐ Alternate work schedule
- ☐ Other (specify): _____

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

_____/_____/_____

Expenditure:

- ☐ Calendar year _____
- ☐ Fiscal year ending

SOCIAL SECURITY, MEDICARE, FUTA (Benefit 15, 16, 19) Sched. # _____

Date of expected change (DOEC): _____

Are all employees covered by:

Social Security: ☐ Yes ☐ No
Medicare: ☐ Yes ☐ No
FUTA: ☐ Yes ☐ No

Participation: (Enter % of quote employment, Not determinable, Not applicable)

Benefit	Quotes								
	All	1	2	3	4	5	6	7	8
Social Security									
Medicare									
FUTA									

Does employer report tips for any sampled occupation? ☐ Yes (Answer table) ☐ No

Quote:	All	1	2	3	4	5	6	7	8
Average Hourly Rate									
Average Tips Per Hour									
Total Employees									

Remarks/Calculations:

STATE UNEMPLOYMENT INSURANCE, WORKERS' COMPENSATION (Benefits 20, 21)

Sched. # _____

STATE UNEMPLOYMENT INSURANCE

Quotes: _____ Date of expected change (DOEC): _____

Eligibility: _____ Plan name: _____

Financing:

☐ State Insured (Enter rate and add-on data below if different from State)

Rate _____%

Add-on rate(s), if any _____%

☐ Self-Insured/Reimbursement

☐ Railroad plan

☐ Nonprofit plan

Does employer report tips for any sampled occupation? ☐ Yes (Answer table) ☐ No

Quote:	**ALL**	1	2	3	4	5	6	7	8
Average Hourly Rate									
Average Tips Per Hour									
Total Employees									

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

Expenditure:

☐ Calendar year _____

☐ Fiscal year ending ____/_____/____

WORKERS' COMPENSATION

Quotes: _____ Date of expected change (DOEC): _____

Eligibility: _____ Plan name: _____

Financing:

☐ Self-Insured ☐ Commercially Insured (Answer grid)

QUOTE	W.C. Code	Rate	Experience Modifier	Premium Discount
1				
2				
3				
4				
5				
6				
7				
8				

Expenditure cost: $_____

# of employees: _____

☐ GR or ☐ SE Payroll = $ _____

Expenditure:

☐ Calendar year _____

☐ Fiscal year ending ____/_____/____

Emerging Benefits

Sched. # _____

Date of expected change (DOEC): _____

Eligibility: _____ Plan name: _____

Benefit	Access for each benefit			Quotes							
	ND*	All	None	1	2	3	4	5	6	7	8
Adoption assistance											
Child care:											
Funds											
On/off-site facility											
Resource and referral service											
Education:											
Non-work related											
Work-related											
Employee assistance programs											
Employer-provided home computers											
Fitness centers											
Flexible work site											
Long-term care											
Medical savings accounts											
OOS Salary reduction											
Sec. 125 Cafeteria benefits:											
Flexible benefits											
Health care reimbursement accounts											
Dependent care reimbursement accounts											
Stock options											
Signing											
Performance											
Other											
Subsidized commuting											
Travel accident insurance											
Wellness programs											

*ND = Not determinable

Sched. # _____

Cost Grids

Overtime

Quote	Status Code	Value Entry	Conversion Code	Annual Overtime Hours	Average Premium	AWS*
ALL						
1						
2						
3						
4						
5						
6						
7						
8						

*AWS= Alternate Work Schedule

Vacation

Quote	Status Code	Value Entry	Conversion Code	Paid Weeks	Unpaid Weeks	AWS*
ALL						
1						
2						
3						
4						
5						
6						
7						
8						

*AWS= Alternate Work Schedule

Holiday

Quote	Status Code	Value Entry	Conversion Code	Paid Days	Unpaid Days	AWS*
ALL						
1						
2						
3						
4						
5						
6						
7						
8						

*AWS= Alternate Work Schedule

Sched. # _____

Sick Leave

Quote	Status Code	Value Entry	Conversion Code	Paid Days	Unpaid Days	AWS*
ALL						
1						
2						
3						
4						
5						
6						
7						
8						

*AWS= Alternate Work Schedule

Other Leave

Quote	Status Code	Value Entry	Conversion Code	Paid Days	Unpaid Days	AWS*
ALL						
1						
2						
3						
4						
5						
6						
7						
8						

*AWS= Alternate Work Schedule

Nonproduction Bonus

Quote	Status Code	Value Entry	Conversion Code	Paid Days	AWS*
ALL					
1					
2					
3					
4					
5					
6					
7					
8					

*AWS= Alternate Work Schedule

Sched. # _____

Life Insurance

Quote	Status Code	Value Entry	Multi Earnings Cov.	Flat Amount Cov.	Conversion Code	Ceiling	AWS*
ALL							
1							
2							
3							
4							
5							
6							
7							
8							

*AWS= Alternate Work Schedule

Health Insurance

Quote	Status Code	Value Entry	Conversion Code	AWS*
ALL				
1				
2				
3				
4				
5				
6				
7				
8				

*AWS= Alternate Work Schedule

Short-term Disability

Quote	Status Code	Value Entry	Conversion Code	Ceiling	AWS*
ALL					
1					
2					
3					
4					
5					
6					
7					
8					

*AWS= Alternate Work Schedule

Sched. # _____

Long-term Disability

Quote	Status Code	Value Entry	Conversion Code	Ceiling	AWS*
ALL					
1					
2					
3					
4					
5					
6					
7					
8					

*AWS= Alternate Work Schedule

Defined Contribution

Quote	Status Code	Value Entry	Conversion Code	Ceiling	AWS*
ALL					
1					
2					
3					
4					
5					
6					
7					
8					

*AWS= Alternate Work Schedule

Defined Benefit

Quote	Status Code	Value Entry	Conversion Code	Ceiling	AWS*
ALL					
1					
2					
3					
4					
5					
6					
7					
8					

*AWS= Alternate Work Schedule

Sched. # _____

Social Security

Quote	Status Code	Legally Required Factor	Value Entry	Conversion Code	AWS*
ALL					
1					
2					
3					
4					
5					
6					
7					
8					

*AWS= Alternate Work Schedule

Medicare

Quote	Status Code	Legally Required Factor	Value Entry	Conversion Code	AWS*
ALL					
1					
2					
3					
4					
5					
6					
7					
8					

*AWS= Alternate Work Schedule

FUTA

Quote	Status Code	Legally Required Factor	Value Entry	Conversion Code	AWS*
ALL					
1					
2					
3					
4					
5					
6					
7					
8					

*AWS= Alternate Work Schedule

Sched. # _____

State Unemployment Insurance

Quote	Status Code	Value Entry	Conversion Code	Ceiling	AWS*
ALL					
1					
2					
3					
4					
5					
6					
7					
8					

*AWS= Alternate Work Schedule

Workers' Compensation

Quote	Status Code	Value Entry	Conversion Code	Ceiling	Rate	Exp. Mod	Prem. Disc	AWS*
ALL								
1								
2								
3								
4								
5								
6								
7								
8								

*AWS= Alternate Work Schedule

Sched. # _____

Additional tables for health insurance cost and plan participation

Cost: Plan No. _____ (Enter $ amount, No cost, Not determinable)

Premiums	Company (ER) Cost	Employee (EE) Cost	Conversion Code	Total Cost
Single				
Family				
EMP. + Spouse				
EMP. + Child				
EMP. + 1				
EMP. + 2				
EMP. + 3				
EMP. + 4				
OTHER:_____				

Participation: Plan No. _____ (Enter % of quote employment, Not determinable, Not applicable)

	Quotes							
	1	2	3	4	5	6	7	8
Single								
Family								
EMP. + Spouse								
EMP. + Child								
EMP. + 1								
EMP. + 2								
EMP. + 3								
EMP. + 4								
Total part.								

Cost: Plan No. _____ (Enter $ amount, No cost, Not determinable)

Premiums	Company (ER) Cost	Employee (EE) Cost	Conversion Code	Total Cost
Single				
Family				
EMP. + Spouse				
EMP. + Child				
EMP. + 1				
EMP. + 2				
EMP. + 3				
EMP. + 4				
OTHER:_____				

Participation: Plan No. _____ (Enter % of quote employment, Not determinable, Not applicable)

	Quotes							
	1	2	3	4	5	6	7	8
Single								
Family								
EMP. + Spouse								
EMP. + Child								
EMP. + 1								
EMP. + 2								
EMP. + 3								
EMP. + 4								
Total part.								

Sched. # _____

Cost: Plan No. _____ (Enter $ amount, No cost, Not determinable)

Premiums	Company (ER) Cost	Employee (EE) Cost	Conversion Code	Total Cost
Single				
Family				
EMP. + Spouse				
EMP. + Child				
EMP. + 1				
EMP. + 2				
EMP. + 3				
EMP. + 4				
OTHER:_____				

Participation: Plan No. _____ (Enter % of quote employment, Not determinable, Not applicable)

	Quotes							
	1	2	3	4	5	6	7	8
Single								
Family								
EMP. + Spouse								
EMP. + Child								
EMP. + 1								
EMP. + 2								
EMP. + 3								
EMP. + 4								
Total part.								

Cost: Plan No. _____ (Enter $ amount, No cost, Not determinable)

Premiums	Company (ER) Cost	Employee (EE) Cost	Conversion Code	Total Cost
Single				
Family				
EMP. + Spouse				
EMP. + Child				
EMP. + 1				
EMP. + 2				
EMP. + 3				
EMP. + 4				
OTHER:_____				

Participation: Plan No. _____ (Enter % of quote employment, Not determinable, Not applicable)

	Quotes							
	1	2	3	4	5	6	7	8
Single								
Family								
EMP. + Spouse								
EMP. + Child								
EMP. + 1								
EMP. + 2								
EMP. + 3								
EMP. + 4								
Total part.								

Sched. # _____

Cost: Plan No. _____ (Enter $ amount, No cost, Not determinable)

Premiums	Company (ER) Cost	Employee (EE) Cost	Conversion Code	Total Cost
Single				
Family				
EMP. + Spouse				
EMP. + Child				
EMP. + 1				
EMP. + 2				
EMP. + 3				
EMP. + 4				
OTHER:_____				

Participation: Plan No. _____ (Enter % of quote employment, Not determinable, Not applicable)

	Quotes							
	1	2	3	4	5	6	7	8
Single								
Family								
EMP. + Spouse								
EMP. + Child								
EMP. + 1								
EMP. + 2								
EMP. + 3								
EMP. + 4								
Total part.								

Cost: Plan No. _____ (Enter $ amount, No cost, Not determinable)

Premiums	Company (ER) Cost	Employee (EE) Cost	Conversion Code	Total Cost
Single				
Family				
EMP. + Spouse				
EMP. + Child				
EMP. + 1				
EMP. + 2				
EMP. + 3				
EMP. + 4				
OTHER:_____				

Participation: Plan No. _____ (Enter % of quote employment, Not determinable, Not applicable)

	Quotes							
	1	2	3	4	5	6	7	8
Single								
Family								
EMP. + Spouse								
EMP. + Child								
EMP. + 1								
EMP. + 2								
EMP. + 3								
EMP. + 4								
Total part.								