

<b>Form 5500</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Annual Return/Report of Employee Benefit Plan</b>  This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).  <b>► Complete all entries in accordance with the instructions to the Form 5500.</b>	OMB Nos. 1210-0110 1210-0089  <div style="text-align: center; font-size: 24pt;"><b>2009</b></div>
		<b>This Form is Open to Public Inspection</b>

<b>Part I</b>	<b>Annual Report Identification Information</b>
For calendar plan year 2009 or fiscal plan year beginning <u>07/01/2008</u> and ending <u>06/30/2009</u>	
<b>A</b> This return/report is for:	<input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan; or <input type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) ____
<b>B</b> This return/report is:	<input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report; <input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months).
<b>C</b> If the plan is a collectively-bargained plan, check here. . . . .	<input type="checkbox"/>
<b>D</b> Check box if filing under:	<input type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description)

<b>Part II</b>	<b>Basic Plan Information</b> —enter all requested information
<b>1a</b> Name of plan <u>EAST HILLS MEDICAL SERVICES PC DEFINED BENEFIT PLAN AND TRUST</u>	<b>1b</b> Three-digit plan number (PN) ► <u>002</u> <b>1c</b> Effective date of plan <u>07/01/2007</u>
<b>2a</b> Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) <u>EAST HILLS MEDICAL SERVICES PC</u>  <u>6 HELEN DR</u> <u>ROSLYN HEIGHTS, NY 11577</u>	<b>2b</b> Employer Identification Number (EIN) <u>20-0268899</u> <b>2c</b> Sponsor's telephone number  <b>2d</b> Business code (see instructions)  <div style="background-color: #cccccc; height: 40px;"></div>

**Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.**

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

<b>SIGN HERE</b>			
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

**Form 5500 (2009)**  
v.092307.1

<b>3a</b> Plan administrator's name and address (if same as plan sponsor, enter "Same") EAST HILLS MEDICAL SERVICES PC  6 HELEN DR ROSLYN HEIGHTS, NY 11577	<b>3b</b> Administrator's EIN 20-0268899  <b>3c</b> Administrator's telephone number  <div style="background-color: #cccccc; height: 30px; width: 100%;"></div>
<b>4</b> If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:  <b>a</b> Sponsor's name	<b>4b</b> EIN  <b>4c</b> PN
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>
<b>6</b> Number of participants as of the end of the plan year (welfare plans complete only lines <b>6a</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).	
<b>a</b> Active participants.....	<b>6a</b>
<b>b</b> Retired or separated participants receiving benefits.....	<b>6b</b>
<b>c</b> Other retired or separated participants entitled to future benefits.....	<b>6c</b>
<b>d</b> Subtotal. Add lines <b>6a</b> , <b>6b</b> , and <b>6c</b> .....	<b>6d</b>
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	<b>6e</b>
<b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....	<b>6f</b>
<b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	<b>6g</b>
<b>h</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6h</b>
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>

**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

<b>9a</b> Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	<b>9b</b> Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
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**10** Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

<b>a Pension Schedules</b> (1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information) (2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary  (3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	<b>b General Schedules</b> (1) <input type="checkbox"/> <b>H</b> (Financial Information) (2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan) (3) <input type="checkbox"/> <b>A</b> (Insurance Information) (4) <input type="checkbox"/> <b>C</b> (Service Provider Information) (5) <input type="checkbox"/> <b>D</b> (DFE/Participating Plan Information) (6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)
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Form 5500

Department of the Treasury  
Internal Revenue ServiceDepartment of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

## Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee

Retirement Income Security Act of 1974 (ERISA) and sections 6047(a),

6057(b), and 6050(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with  
the instructions to the Form 5500.Official Use Only  
OMB Nos. 1210-0110  
1210-0009

2008

This Form is Open to  
Public Inspection.

## Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning 07/01/2008, and ending 06/30/2009.

- A This return/report is for: (1) ☐ a multiemployer plan; (3) ☐ a multiple-employer plan; or  
(2) ☒ a single-employer plan (other than a (4) ☐ a OFE (specify) \_\_\_\_\_  
multiple-employer plan);
- B This return/report is: (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;  
(2) ☐ an amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C If the plan is a collectively-bargained plan, check here \_\_\_\_\_ ▶ ☐
- D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions). \_\_\_\_\_ ▶ ☐

## Basic Plan Information — enter all requested information.

1a Name of plan EAST HILLS MEDICAL SERVICES PC DEFINED BENEFIT PLAN AND TRUST	1b Three-digit plan number (PN) ▶ 002
	1c Effective date of plan (mo., day, yr.) 07/01/2007
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) EAST HILLS MEDICAL SERVICES PC  6 HELEN DR  ROSLYN HEIGHTS NY 11577-2229	2b Employer identification number (EIN) 20-0268899
	2c Sponsor's telephone number 516-626-2559
	2d Business code (see instructions) 621111

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

Date

HELEN M MARKS MD

Type or print name of individual signing as plan administrator

SIGNATURE

Signature of employer/plan sponsor/DFE

Date

Type or print name of individual signing as employer, plan sponsor or OFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

v11.3

Form 5500 (2008)



**3a** Plan administrator's name and address (If same as plan sponsor, enter "Same")  
SAME

**3b** Administrator's EIN

**3c** Administrator's telephone number

**4** If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

**a** Sponsor's name

**b** EIN

**c** PN

**5** Preparer information (optional) **a** Name (including firm name, if applicable) and address

**b** EIN

**c** Telephone number

**6** Total number of participants at the beginning of the plan year

**6** 1

**7** Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

**a** Active participants

**7a** 1

**b** Retired or separated participants receiving benefits

**7b** 0

**c** Other retired or separated participants entitled to future benefits

**7c** 0

**d** Subtotal. Add lines 7a, 7b, and 7c

**7d** 1

**e** Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

**7e** 0

**f** Total. Add lines 7d and 7e

**7f** 1

**g** Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

**7g**

**h** Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

**7h** 0

**i** If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

**7i** 0

**8** Benefits provided under the plan (complete 8a and 8b, as applicable)

**a** ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): 3B 3E 3G 3H 1A

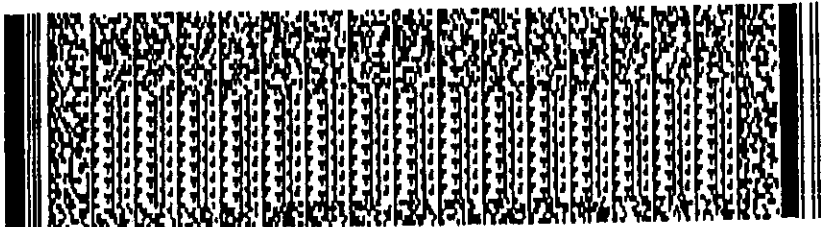
**b** ☒ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions): 4B

**9a** Plan funding arrangement (check all that apply)

- (1) ☐ Insurance  
(2) ☒ Code section 412(a)(3) insurance contracts  
(3) ☐ Trust  
(4) ☐ General assets of the sponsor

**9b** Plan benefit arrangement (check all that apply)

- (1) ☐ Insurance  
(2) ☒ Code section 412(e)(3) insurance contracts  
(3) ☐ Trust  
(4) ☐ General assets of the sponsor

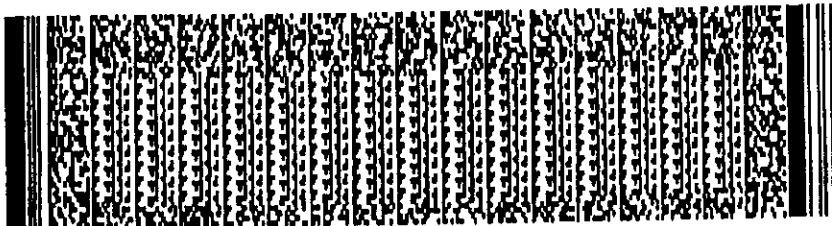


**10 Schedules attached** (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)**a Pension Benefit Schedules**

- |     |                                     |     |  |
|-----|-------------------------------------|-----|--|
| (1) | <input checked="" type="checkbox"/> | R   | (Retirement Plan Information)              |
| (2) | <input type="checkbox"/>            | B   | (Actuarial Information)                    |
| (3) | <input type="checkbox"/>            | E   | (ESOP Annual Information)                  |
| (4) | <input type="checkbox"/>            | SSA | (Separated Vested Participant Information) |

**b Financial Schedules**

- |     |                                     |     |                                       |
|-----|-------------------------------------|-----|---------------------------------------|
| (1) | <input type="checkbox"/>            | H   | (Financial Information)               |
| (2) | <input type="checkbox"/>            | I   | (Financial Information -- Small Plan) |
| (3) | <input checked="" type="checkbox"/> | 1 A | (Insurance Information)               |
| (4) | <input type="checkbox"/>            | C   | (Service Provider Information)        |
| (5) | <input type="checkbox"/>            | D   | (DFE/Participating Plan Information)  |
| (6) | <input type="checkbox"/>            | G   | (Financial Transaction Schedules)     |



**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service  
Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

This schedule is required to be filed under section 104 of the  
Employee Retirement Income Security Act of 1974.

► File as an attachment to Form 5500.

► Insurance companies are required to provide this information  
pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

**2008**

This Form is Open to  
Public Inspection.

For calendar plan year 2008 or fiscal plan year beginning 07/01/2008 and ending 06/30/2009

<b>A</b> Name of plan EAST HILLS MEDICAL SERV PC DB	<b>B</b> Three-digit plan number ► 2
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 EAST HILLS MEDICAL	<b>D</b> Employer Identification Number 20-0268899

**Part III Information Concerning Insurance Contract Coverage, Fees, and Commissions**

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1 Coverage:**

(a) Name of insurance carrier

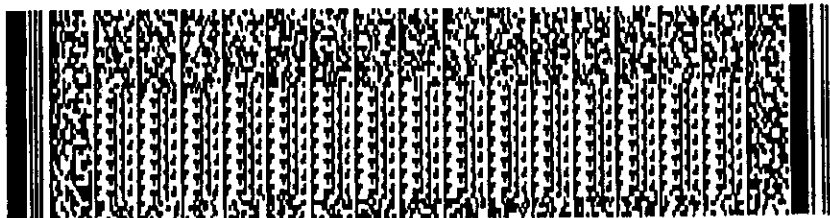
NATIONAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
03-0144090	66680	0346720	2		

**2** Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals	
Total amount of commissions paid	Total fees paid / amount
6964	1086

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v11.3 Schedule A (Form 5500) 2008



National Life Insurance Company certifies that the foregoing statement is complete and accurate based on information in our insurance records.

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

HOWARD LESTER POLANSKY  
2ND FLOOR 733 3RD AVE  
NEW YORK

NY

10017-3204

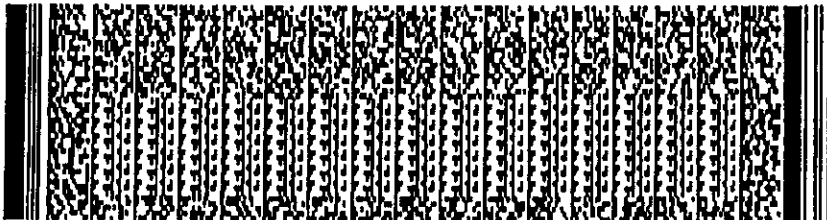
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
6964	1086	NON-MONETARY COMPENSATION	3

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	0		

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	0		

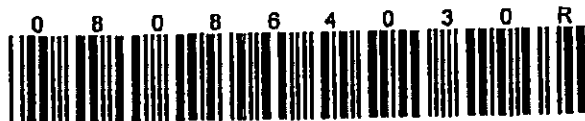
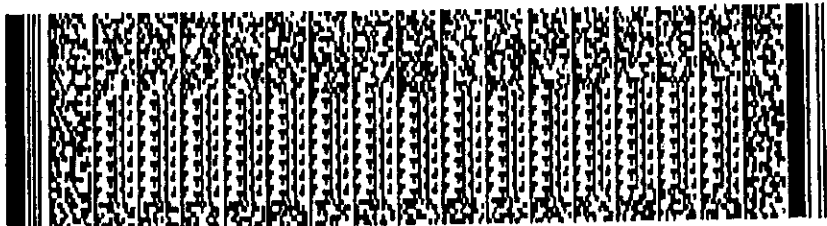


National Life Insurance Company certifies that the foregoing statement is complete and accurate based on information in our insurance records.

**Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

<b>3</b>	Current value of plan's interest under this contract in the general account at year end .....	0
<b>4</b>	Current value of plan's interest under this contract in separate accounts at year end .....	0
<b>5</b>	<b>Contracts With Allocated Funds</b>	
<b>a</b>	State the basis of premium rates <b>▶ BASED ON SCHEDULES FILED W/STATE</b>	140226
<b>b</b>	Premiums paid to carrier .....	0
<b>c</b>	Premiums due but unpaid at the end of the year .....	0
<b>d</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount .....	0
	Specify nature of costs ▶ .....	
<b>e</b>	Type of contract (1) <input checked="" type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶ .....	
<b>f</b>	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here .....	<input type="checkbox"/>
<b>6</b>	<b>Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)</b>	
<b>a</b>	Type of contract (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other (specify below) .....	
<b>b</b>	Balance at the end of the previous year .....	0
<b>c</b>	Additions: (1) Contributions deposited during the year .....	0
	(2) Dividends and credits .....	0
	(3) Interest credited during the year .....	0
	(4) Transferred from separate account .....	0
	(5) Other (specify below) .....	0
	▶ .....	0
(6)	Total additions .....	0
<b>d</b>	Total of balance and additions (add b and c(6)) .....	0
<b>e</b>	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year .....	0
	(2) Administration charge made by carrier .....	0
	(3) Transferred to separate account .....	0
	(4) Other (specify below) .....	0
	▶ .....	0
(5)	Total deductions .....	0
<b>f</b>	Balance at the end of the current year (subtract e(5) from d) .....	0



National Life Insurance Company certifies that the foregoing statement is complete and accurate based on information in our insurance records.



**Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes on this report.

<b>7 Benefit and contract type (check all applicable boxes)</b>			
<b>a</b> <input type="checkbox"/> Health (other than dental or vision)	<b>b</b> <input type="checkbox"/> Dental	<b>c</b> <input type="checkbox"/> Vision	<b>d</b> <input type="checkbox"/> Life insurance
<b>e</b> <input type="checkbox"/> Temporary disability (accident and sickness)	<b>f</b> <input type="checkbox"/> Long-term disability	<b>g</b> <input type="checkbox"/> Supplemental unemployment	<b>h</b> <input type="checkbox"/> Prescription drug
<b>i</b> <input type="checkbox"/> Stop loss (large deductible)	<b>j</b> <input type="checkbox"/> HMO contract	<b>k</b> <input type="checkbox"/> PPO contract	<b>l</b> <input type="checkbox"/> Indemnity contract
<b>m</b> <input type="checkbox"/> Other (specify) ▶			

<b>8 Experience-rated contracts</b>		
<b>a</b> Premiums: (1) Amount received	0	
(2) Increase (decrease) in amount due but unpaid	0	
(3) Increase (decrease) in unearned premium reserve	0	
(4) Earned ((1) + (2) - (3))	0	0
<b>b</b> Benefit charges: (1) Claims paid	0	
(2) Increase (decrease) in claim reserves	0	
(3) Incurred claims (add (1) and (2))		0
(4) Claims charged		0
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --		
(A) Commissions	0	
(B) Administrative service or other fees	0	
(C) Other specific acquisition costs	0	
(D) Other expenses	0	
(E) Taxes	0	
(F) Charges for risks or other contingencies	0	
(G) Other retention charges	0	
(H) Total retention		0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		0
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		0
(2) Claim reserves		0
(3) Other reserves		0
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		0
<b>9 Nonexperience-rated contracts:</b>		
<b>a</b> Total premiums or subscription charges paid to carrier		0
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount		0
Specify nature of costs ▶		



National Life Insurance Company certifies that the foregoing statement is complete and accurate based on information in our insurance records.

**SCHEDULE R  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service  
Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

**Retirement Plan Information**

This schedule is required to be filed under sections 104 and 4085 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

► File as an Attachment to Form 5500.

Official Use Only

OMB No. 1521-0110


**2008**

This Form is Open to  
Public Inspection.

For calendar year 2008 or fiscal plan year beginning <b>07/01/2008</b> and ending <b>06/30/2009</b>	
<b>A</b> Name of plan <b>EAST HILLS MEDICAL SERVICES PC DEFINED BENEFIT PLAN</b>	<b>B</b> Three-digit plan number <b>002</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>EAST HILLS MEDICAL SERVICES PC</b>	<b>D</b> Employer Identification Number <b>20-0268899</b>

**Distributions**

All references to distributions relate only to payments of benefits during the plan year.

- 1** Total value of distributions paid in property other than in cash or the forms of property specified in the instructions . . . . . **1** \$ 
- 2** Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the plan year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). . . . .
- Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.
- 3** Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year . . . . . **3** **0**

**Funding Information** (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)

- 4** Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? . . . . . ☐ Yes ☐ No ☒ N/A
- If the plan is a defined benefit plan, go to line 7.
- 5** If a waiver of the minimum funding standard for a prior plan year is being amortized in this plan year, see instructions, and enter the date of the ruling letter granting the waiver . . . . . Month  Day  Year
- If you completed line 5, complete lines 6a, 6b, and 6c of Schedule MB and do not complete the remainder of this schedule.
- 6a** Enter the minimum required contribution for this plan year . . . . . **6a** \$
- b** Enter the amount contributed by the employer to the plan for this plan year . . . . . **6b** \$
- c** Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) . . . . . **6c** \$
- If you completed line 6c, skip lines 7 and 8 and complete line 9.
- 7** If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? . . . . . ☐ Yes ☐ No ☒ N/A

**Amendments**

- 8** If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box(es). If no, check the "No" box. (See instructions.) . . . . . ☐ Increase ☐ Decrease ☒ No

**Coverage (See instructions.)**

- 9** Check the box for the test this plan used to satisfy the coverage requirements . . . . . ☐ ratio percentage test ☐ average benefit test
- For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v11.3 Schedule R (Form 5500) 2008

