

<b>Form 5500-SF</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Short Form Annual Return/Report of Small Employee Benefit Plan</b>  This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).  <b>▶ Complete all entries in accordance with the instructions to the Form 5500-SF.</b>	OMB Nos. 1210-0110 1210-0089  <b>2020</b>  <b>This Form is Open to Public Inspection</b>
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<b>Part I</b>	<b>Annual Report Identification Information</b>
For calendar plan year 2020 or fiscal plan year beginning <u>01/01/2020</u> and ending <u>12/31/2020</u>	
A	This return/report is for: <input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
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)
C	Check box if filing under: <input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)

<b>Part II</b>	<b>Basic Plan Information</b> —enter all requested information		
1a	Name of plan <u>HOOSICK FALLS HEALTH CENTER, INC. EMPLOYEES RETIREMENT PLAN</u>	1b	Three-digit plan number (PN) ▶ <u>002</u>
		1c	Effective date of plan <u>06/01/1996</u>
2a	Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>HOOSICK FALLS HEALTH CENTER, INC.</u>  <u>21 DANFORTH STREET</u> <u>HOOSICK FALLS, NY 12090</u>	2b	Employer Identification Number (EIN) <u>14-1370000</u>
		2c	Sponsor's telephone number <u>518-686-4371</u>
		2d	Business code (see instructions) <u>623000</u>
3a	Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	3b	Administrator's EIN
		3c	Administrator's telephone number
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name	4b	EIN
		4d	PN
5a	Total number of participants at the beginning of the plan year .....	5a	<u>120</u>
b	Total number of participants at the end of the plan year .....	5b	<u>120</u>
c	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	5c	<u>23</u>
d(1)	Total number of active participants at the beginning of the plan year .....	5d(1)	<u>111</u>
d(2)	Total number of active participants at the end of the plan year .....	5d(2)	<u>111</u>
e	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .....	5e	<u>0</u>
<b>Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.</b>			
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, 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.			
SIGN HERE	<u>Filed with authorized/valid electronic signature.</u>	<u>10/12/2021</u>	<u>SUZANNE ANAIR</u>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<u>Filed with authorized/valid electronic signature.</u>		
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) ..... ☒ Yes ☐ No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) ..... ☒ Yes ☐ No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ..... ☐ Yes ☐ No ☐ Not determined
- If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year ..... (See instructions.)

**Part III Financial Information**

<b>7</b> Plan Assets and Liabilities		<b>(a) Beginning of Year</b>	<b>(b) End of Year</b>
<b>a</b> Total plan assets .....	<b>7a</b>	825733	800001
<b>b</b> Total plan liabilities .....	<b>7b</b>		
<b>c</b> Net plan assets (subtract line 7b from line 7a) .....	<b>7c</b>	825733	800001
<b>8</b> Income, Expenses, and Transfers for this Plan Year		<b>(a) Amount</b>	<b>(b) Total</b>
<b>a</b> Contributions received or receivable from:			
<b>(1)</b> Employers .....	<b>8a(1)</b>		
<b>(2)</b> Participants .....	<b>8a(2)</b>		
<b>(3)</b> Others (including rollovers) .....	<b>8a(3)</b>		
<b>b</b> Other income (loss) .....	<b>8b</b>	93061	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) .....	<b>8c</b>		93061
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits) .....	<b>8d</b>	118118	
<b>e</b> Certain deemed and/or corrective distributions (see instructions) .	<b>8e</b>		
<b>f</b> Administrative service providers (salaries, fees, commissions) .....	<b>8f</b>	675	
<b>g</b> Other expenses .....	<b>8g</b>		
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g) .....	<b>8h</b>		118793
<b>i</b> Net income (loss) (subtract line 8h from line 8c) .....	<b>8i</b>		-25732
<b>j</b> Transfers to (from) the plan (see instructions) .....	<b>8j</b>		

**Part IV Plan Characteristics**

- 9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:  
2G 2M 3D
- b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

**Part V Compliance Questions**

<b>10</b> During the plan year:		<b>Yes</b>	<b>No</b>	<b>Amount</b>
<b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program) .....	<b>10a</b>		X	
<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) .....	<b>10b</b>		X	
<b>c</b> Was the plan covered by a fidelity bond? .....	<b>10c</b>	X		1000000
<b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....	<b>10d</b>		X	
<b>e</b> Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.) .....	<b>10e</b>		X	
<b>f</b> Has the plan failed to provide any benefit when due under the plan? .....	<b>10f</b>		X	
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) .....	<b>10g</b>	X		15021
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....	<b>10h</b>		X	
<b>i</b> If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3 .....	<b>10i</b>			

**Part VI Pension Funding Compliance**

**11** Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 12 blank and complete line 11 below. ☐ Yes ☐ No

**a** Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 **11a**

**b PBGC missed contribution reporting requirements.** If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

- ☐ Yes.
- ☐ No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
- ☐ No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
- ☐ No. Other. Provide explanation \_\_\_\_\_

**12** Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above. ☐ Yes ☒ No

**a** If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.**

**b** Enter the minimum required contribution for this plan year **12b**

**c** Enter the amount contributed by the employer to the plan for this plan year **12c**

**d** Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount) **12d**

**e** Will the minimum funding amount reported on line 12d be met by the funding deadline? ☐ Yes ☐ No ☐ N/A

**Part VII Plan Terminations and Transfers of Assets**

**13a** Has a resolution to terminate the plan been adopted in any plan year? ☐ Yes ☒ No

If "Yes," enter the amount of any plan assets that reverted to the employer this year. **13a**

**b** Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? ☐ Yes ☒ No

**c** If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

<b>13c(1)</b> Name of plan(s):	<b>13c(2)</b> EIN(s)	<b>13c(3)</b> PN(s)

# 2020 Plan Information Worksheet

Status:

## Plan Sponsor Information

Plan Sponsor's Name	Plan Sponsor's Mailing Address	Foreign <input type="checkbox"/>
Plan Sponsor's Name		
Hoosick Falls Health Center, Inc.	21 Danforth Street	
Plan Sponsor's Doing Business As Name	Plan Sponsor's Mailing City, Province, State and ZIP	
	Hoosick Falls	NY 12090
Plan Sponsor's Care Of Name	Plan Sponsor's Location Address	Foreign
	Plan Sponsor's Location City, Province, State and ZIP	
Plan Sponsor's EIN		
14-1370000		
Plan Sponsor's Phone Number		
(518)686-4371		

## Plan Administrator Information

<input checked="" type="checkbox"/> Same as Plan Sponsor	Foreign
Plan Administrator's Name	
	Plan Administrator's Address
Plan Administrator's Care Of Name	
	Plan Administrator's City, Province, State and ZIP
Plan Administrator's EIN	
	Plan Administrator's Phone Number

## Plan Information

Plan Name	Business Code	Filing for Plan Year:	DFE Plan
Hoosick Falls Health Center, Inc. Employees Retirement Plan	623000	2020	
	Plan Year	MM/DD/YYYY	MM/DD/YYYY
	Begins	01/01/2020	Ends 12/31/2020
	Tax Year	MM/DD/YYYY	MM/DD/YYYY
	Begins	01/01/2020	Ends 12/31 /2020
Three-digit Plan Number	Plan ID		
002	556533		
EIN for PBGC Forms	Name Control		
	Effective Date of Plan		
	06/01/1996		

## Transmitter Information

Transmitter's TIN	Transmitter Control Code (TCC)	Contact Name
23-2383285	60978	Pam Willis
Transmitter's Name		Contact Telephone Number
Pam Willis		(856)368-2000
Company Name		Contact E-Mail Address

Company Mailing Address

51 Haddonfield Road, Suite 200

Company City, Province, State and ZIP

Cherry Hill

Foreign

NJ 08002

Do NOT File with IRS, DOL or PBGC

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**Preparer Information**

Preparer's Name

Preparer's City, Province, State and ZIP

Preparers Firm Name

Preparer's Phone Number

Preparer's Address

Foreign

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**Trust Information**

Name of Trust

Trust EIN

Name of Trustee or Custodian

Trustee's or Custodian's Phone #

---

**Signers, Service Providers and Interested Individuals**

Notify

Contact Phone Number

Contact Name

E-Mail Address

Contact ID

Notify Plan Administrator

Contact Phone Number

Contact Name

E-Mail Address

Kgreene@svhealthcare.org

Contact ID

Notify Plan Administrator

Contact Phone Number

Contact Name

E-Mail Address

suzanne.anair@svhealthcare.org

Contact ID

☐ Notify

Contact Phone Number

Contact Name

E-Mail Address

Contact ID

☐ Notify

Contact Phone Number

Contact Name

E-Mail Address

Contact ID

☐ Notify

Contact Phone Number

Contact Name

E-Mail Address

Contact ID

# Form 5500-SF

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefit Security Administration

Pension Benefit Guaranty Corporation

## Short Form Annual Return/Report of Small 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 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500-SF.

OMB Nos. 1210-01  
10 1210-  
0089

2020

This Form is Open to  
Public Inspection

### Part I Annual Return Identification Information

☐ Notify

Contact Phone Number

Contact Name

E-Mail Address

Contact ID

☐ Notify

Contact Phone Number

Contact Name

E-Mail Address

Contact ID

For calendar plan year 2020 or fiscal plan year beginning

C

A This return/report is for: a single-employer plan

01/01/2020 and ending 12/31/2020  
a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) the final return/report a short plan year return/report (less than 12 months)

B This return/report is the first return/report  
an amended return/report

Check box if filing under: 5558 automatic extension DFVC program  
special extension (enter description)

Part II Basic Plan Information—enter all requested information in the Name of plan

Hoosick Falls Health Center, Inc. Employees Retirement Plan

2a Plan sponsor's name (employer, if for a single-employer plan)

Mailing address (include room, apt., suite no. and street, or P.O. Box)

City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Hoosick Falls Health Center, Inc.

21 Danforth Street

Hoosick Falls

NY 12090

3a Plan administrator's name and address Same as Plan Sponsor.

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name

C Plan Name

5a Total number of participants at the beginning of the plan year

b Total number of participants at the end of the plan year

C Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) d(l) Total number of active participants at the beginning of the plan year . d(2) Total number of active participants at the end of the plan year e Number of participants who terminated employment during the plan year with accrued benefits that were less

1b Three-digit plan number 002

1c Effective date of plan 06/01/1996

2b Employer Identification Number (EIN)14-1370000

2c Sponsor's telephone number (518) 686-4371

2d Business code (see instructions) 623000

3b Administrator's EIN

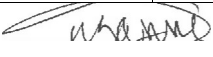
3C Administrator's telephone number

4b EIN

120  
5b 120  
23  
5d(1) 111  
5d(2) 111  
0

than 100% vested .....  
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, if applicable, a Schedule SB or Schedule MBcompt and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief it is true m lete.

SIGN HERE		21	UZÄNNE ÄNÄIR
	natur f lan administrator	Date	Enter name of individual si nin as lan administrator
SIGN HERE			
	Si nature of em lo rl lans nsor	Date	Enter name of individual nin as em 10 eror lan s onsor si

Were all of the plan's assets during the plan year invested in eligible assets? (See

Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.).....

If you answered "No" to either line 5a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.

C If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? .....O Yes NO Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year . (See instructions.)

## Part III Financial Information

7	Plan Assets and Liabilities	a	Beginning of Year	b	End of Year
a	Total plan assets --- ..... ..		825,733		800,
b	Total plan liabilities .....	7b			001
C	Net plan assets (subtract line 7b from line 7a)		825,733		800 ,
					001
8	Income, Expenses, and Transfers for this Plan Year	a		b	Total
a	Contributions received or receivable from: 1 Employees ...				
	2 Participants..... ..				
	3 Others including rollovers				
b	Other income (loss) .....	8b	93,061		
C	Total income add lines 8a 1, 8a 2, 8a 3, and 8b	8c			93 ,
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits .				061
e	Certain deemed and/or corrective distributions see instructions) .	8e	118,118		
f	Administrative service providers salaries, fees, commissions	8f	675		
	Other expenses .....	8			
h	Total expenses add lines 8d, 8e, 8f, and 8	8h			118,
ij	Net income loss subtract line 8h from line 8c				793
	Transfers to (from) the plan (see instructions).....				-25,
					732

## Part IV Plan Characteristics

9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:  
2G 2M 3D

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

## Part V Compliance Questions

10	During the plan year:	Yes	No	Amount
a	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)			
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.).....	IOa	x	
		10b	x	
C	Was the plan covered by a fidelity bond? ..... ..	IOC	x	
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?.	IOd	x	
e	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.).....		x	



f Has the plan failed to provide any benefit when due under the plan? 1 Of x

g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) .....  
.....

h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) ... IOh x

15,  
021

i If 1 Oh was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3

Form 5500-SF (2020)

Page  
3-

## Part VI Pension Funding Compliance

11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 11 blank and complete line 12 below.....

Yes NO

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500 line 40).

11a

b PBGC missed contribution reporting requirements. If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.

No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.

No. Other. Provide explanation

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? .....  
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above.

☐ Yes ☒ No

a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver.

Month Day Year

If you completed line 12a complete lines 3, 9, and 10 of Schedule MB Form 5500 and skip to line 13.

b Enter the minimum required contribution for this plan year

12b

c Enter the amount contributed by the employer to the plan for this plan year.

12c

d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)

12d

e Will the minimum funding amount reported on line 12d be met by the funding deadline? .....

Yes

No

N/A

## Part VI Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year?

Yes

If "Yes," enter the amount of any plan assets that reverted to the employer this year.

13a

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	Yes
C If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. See instructions.	
13c(1) Name of plan(s):	13c(2) EIN(s)

Form 5558 (Rev. September 2018)  Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Application for Extension of Time To File Certain Employee Plan Returns</h2> <p style="margin: 5px 0;">&gt; For Privacy Act and Paperwork Reduction Act Notice, see instructions. &gt; Go to <a href="http://www.irs.gov/Form5558">www.irs.gov/Form5558</a> for the latest information.</p>	OMB No. 1545-0212  <div style="border: 1px solid black; padding: 5px; text-align: center;">File With IRS only</div>
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### Part I Identification

Name of filer, plan administrator, or plan sponsor (see instructions) Hoosick Falls Health Center, Inc.	<b>B</b> Filer's identifying number (see instructions) Employer identification number (EIN) (9 digits)  14-1370000  Social security number (SSN) (9 digits XXX-XX-X)000
Number, street, and room or suite no. (If a P.O. box, see instructions) 21 Danforth Street	
City or town, state, and ZIP code Hoosick Falls NY 12090	

C Plan name	number	Plan year ending— MM		
Hoosick Falls Health Center, Inc. Employees Retirement Plan	2	12	31	2020

### Extension of Time To File Form 5500 Series, and/or Form 8955-SSA

Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part I, C above.

2 I request an extension of time until 10 / 15 / 2021 to file Form 5500 series. See instructions. Note: A signature IS NOT required if you are requesting an extension to file Form 5500 series.

3 I request an extension of time until 10 / 15 / 2021 to file Form 8955-SSA. See instructions. Note: A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.

The application is automatically approved to the date shown on line 2 and/or line 3 (above) if (a) the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested; and (b) the date on line 2 and/or line 3 (above) is not later than the 15th day of the 3rd month after the normal due date.

### Part III Extension of Time To File Form 5330 (see instructions)

4 I request an extension of time until \_\_\_\_\_ to file Form 5330.  
 You may be approved for up to a 6-month extension to file Form 5330, after the normal due date of Form 5330.

a Enter the Code section(s) imposing the tax

. . . . . ▶ a \_\_\_\_\_

b Enter the payment amount attached. . . . . ▶

b

C For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date . . .

c

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Signature 

Date ▶

Form 5558 (Rev. 9-2018)