# Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Annual Return/Report of Employee Benefit Plan

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 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

**2020**

**This Form is Open to Public Inspection**

## Part I Annual Report Identification Information

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

**A** This return/report is for:
- [ ] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
- [X] a single-employer plan
- [ ] a DFE (specify) ____

**B** This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [ ] a short plan year return/report (less than 12 months)

**C** If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

**D** Check box if filing under:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

## Part II Basic Plan Information—enter all requested information

**1a** Name of plan
DENTAL INSURANCE FOR ALL EMPLOYEES OF HILL MECHANICAL GROUP

**1b** Three-digit plan number (PN) ▶ 503

**1c** Effective date of plan 01/01/1998

**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)
HILL MECHANICAL GROUP

11045 GAGE AVE
FRANKLIN PARK, IL 60131-1437

11045 GAGE AVE
FRANKLIN PARK, IL 60131-1437

**2b** Employer Identification Number (EIN) 36-1334975

**2c** Plan Sponsor's telephone number 847-451-5000

**2d** Business code (see instructions) 238220

**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.

| | | | |
|---|---|---|---|
| **SIGN HERE** | Filed with authorized/valid electronic signature. | 10/15/2021 | TAMI FARBER |
| | **Signature of plan administrator** | Date | Enter name of individual signing as plan administrator |
| **SIGN HERE** | | | |
| | **Signature of employer/plan sponsor** | Date | Enter name of individual signing as employer or plan sponsor |
| **SIGN HERE** | | | |
| | **Signature of DFE** | Date | Enter name of individual signing as DFE |

**3a** Plan administrator's name and address [X] 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

| | | |
|---|---|---|
| **5** Total number of participants at the beginning of the plan year | **5** | 212 |
| **6** Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**). | | |
| **a(1)** Total number of active participants at the beginning of the plan year | **6a(1)** | 212 |
| **a(2)** Total number of active participants at the end of the plan year | **6a(2)** | 195 |
| **b** Retired or separated participants receiving benefits | **6b** | |
| **c** Other retired or separated participants entitled to future benefits | **6c** | |
| **d** Subtotal. Add lines **6a(2)**, **6b**, and **6c** | **6d** | 195 |
| **e** Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. | **6e** | |
| **f** Total. Add lines **6d** and **6e** | **6f** | 195 |
| **g** Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) | **6g** | |
| **h** Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested | **6h** | |
| **7** Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | **7** | |

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

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

4D

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

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

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

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

**10** Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

**a Pension Schedules**

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

**b General Schedules**

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 1 **A** (Insurance Information)
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

## Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

**11a** If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

**11b** Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

**11c** Enter the Receipt Confirmation Code for the 2020 Form M-1 annual report. If the plan was not required to file the 2020 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

# 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 (ERISA).

▶ **File as an attachment to Form 5500.**

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

OMB No. 1210-0110

**2020**

**This Form is Open to Public Inspection**

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

**A** Name of plan
DENTAL INSURANCE FOR ALL EMPLOYEES OF HILL MECHANICAL GROUP

**B** Three-digit plan number (PN) ▶ 503

**C** Plan sponsor's name as shown on line 2a of Form 5500
HILL MECHANICAL GROUP

**D** Employer Identification Number (EIN)
36-1334975

## Part I 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 Information:

**(a)** Name of insurance carrier
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

| (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 |
| 13-5123390 | 64246 | 00473154 | 195 | 01/01/2020 | 12/31/2020 |

**2** Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

| (a) Total amount of commissions paid | (b) Total amount of fees paid |
|---|---|
| 8852 | 0 |

**3** Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---|---|---|
| | (c) Amount | (d) Purpose | |
| | | | |

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---|---|---|
| | (c) Amount | (d) Purpose | |
| | | | |

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

| **(b)** Amount of sales and base commissions paid | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

| **(b)** Amount of sales and base commissions paid | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

| **(b)** Amount of sales and base commissions paid | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

| **(b)** Amount of sales and base commissions paid | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

| **(b)** Amount of sales and base commissions paid | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

## Part II 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.

| | | | |
|---|---|---|---|
| **4** | Current value of plan's interest under this contract in the general account at year end | **4** | |
| **5** | Current value of plan's interest under this contract in separate accounts at year end | **5** | |

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

| | | | |
|---|---|---|---|
| **b** | Premiums paid to carrier | **6b** | |
| **c** | Premiums due but unpaid at the end of the year | **6c** | |
| **d** | 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. | **6d** | |

Specify nature of costs ▶

**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

| | | | | | |
|---|---|---|---|---|---|
| **b** | Balance at the end of the previous year | | | **7b** | |
| **c** | Additions: (1) Contributions deposited during the year | **7c(1)** | | | |
| | (2) Dividends and credits | **7c(2)** | | | |
| | (3) Interest credited during the year | **7c(3)** | | | |
| | (4) Transferred from separate account | **7c(4)** | | | |
| | (5) Other (specify below) | **7c(5)** | | | |
| | ▶ | | | | |
| | (6) Total additions | | | **7c(6)** | |
| **d** | Total of balance and additions (add lines **7b** and **7c(6)**) | | | **7d** | |
| **e** | Deductions: | | | | |
| | (1) Disbursed from fund to pay benefits or purchase annuities during year | **7e(1)** | | | |
| | (2) Administration charge made by carrier | **7e(2)** | | | |
| | (3) Transferred to separate account | **7e(3)** | | | |
| | (4) Other (specify below) | **7e(4)** | | | |
| | ▶ | | | | |
| | (5) Total deductions | | | **7e(5)** | |
| **f** | Balance at the end of the current year (subtract line **7e(5)** from line **7d**) | | | **7f** | |

## Part III 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 organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [X] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

| | | | | |
|---|---|---|---|---|
| **9** Experience-rated contracts: | | | | |
| **a** Premiums: (1) Amount received | **9a(1)** | | | |
| (2) Increase (decrease) in amount due but unpaid | **9a(2)** | | | |
| (3) Increase (decrease) in unearned premium reserve | **9a(3)** | | | |
| (4) Earned (**(1)** + **(2)** - **(3)**) | | | **9a(4)** | |
| **b** Benefit charges (1) Claims paid | **9b(1)** | 103844 | | |
| (2) Increase (decrease) in claim reserves | **9b(2)** | | | |
| (3) Incurred claims (add **(1)** and **(2)**) | | | **9b(3)** | 103844 |
| (4) Claims charged | | | **9b(4)** | |
| **c** Remainder of premium: (1) Retention charges (on an accrual basis) -- | | | | |
| (A) Commissions | **9c(1)(A)** | | | |
| (B) Administrative service or other fees | **9c(1)(B)** | 13689 | | |
| (C) Other specific acquisition costs | **9c(1)(C)** | | | |
| (D) Other expenses | **9c(1)(D)** | | | |
| (E) Taxes | **9c(1)(E)** | | | |
| (F) Charges for risks or other contingencies | **9c(1)(F)** | | | |
| (G) Other retention charges | **9c(1)(G)** | | | |
| (H) Total retention | | | **9c(1)(H)** | 13689 |
| (2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.) | | | **9c(2)** | |
| **d** Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | | **9d(1)** | |
| (2) Claim reserves | | | **9d(2)** | |
| (3) Other reserves | | | **9d(3)** | |
| **e** Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.) | | | **9e** | |
| **10** Nonexperience-rated contracts: | | | | |
| **a** Total premiums or subscription charges paid to carrier | | | **10a** | |
| **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, line 2 above, report amount. | | | **10b** | |

Specify nature of costs.

## Part IV Provision of Information

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

**12** If the answer to line 11 is "Yes," specify the information not provided. ▶

Form **5558** (Rev. September 2018)

Department of the Treasury Internal Revenue Service

# Application for Extension of Time To File Certain Employee Plan Returns

▶ For Privacy Act and Paperwork Reduction Act Notice, see instructions.
▶ Go to *www.irs.gov/Form5558* for the latest information.

OMB No. 1545-0212

**File With IRS Only**

## Part I Identification

**A** Name of filer, plan administrator, or plan sponsor (see instructions)
Hill Mechanical Group

Number, street, and room or suite no. (If a P.O. box, see instructions)
11045 Gage Ave.

City or town, state, and ZIP code
Franklin Park, IL 60131

**B** Filer's identifying number (see instructions)
Employer identification number (EIN) (9 digits XX-XXXXXXX)
36-1334975

Social security number (SSN) (9 digits XXX-XX-XXXX)

**C**

| Plan name | Plan number | Plan year ending— MM | DD | YYYY |
|---|---|---|---|---|
| Dental Insurance for all employees of Hill Mechanical Group | 5 0 3 | 12 | 31 | 2020 |

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

1 ☑ 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 1 0 /1 5 /2 0 2 1 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 ____ / ____ / ____ 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

5 **State in detail why you need the extension:**

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ▶ [signature] Date ▶ 7/29/21

**Note:** If the filing date falls on a Saturday, Sunday, or a legal holiday, the return may be filed on the next day that is not a Saturday, Sunday, or a legal holiday.

Approved copies of Form 5558 requesting an extension of time to file Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA will not be returned to the filer from the IRS.

**Line 1.** Check this box if the extension of time being requested on line 2 is for the first Form 5500 series return/report filed for the plan. This box should not be checked if the plan previously filed a Form 5500 series return/report at any time for any year.

**Line 2.** Enter on line 2 the due date for which you are requesting to file Form 5500, Form 5500-SF, or Form 5500-EZ. This date should not be later than the 15th day of the 3rd month after the normal due date of the return/report.

When using Form 5558 to request an extension of time to file Form 5500, Form 5500-SF, or Form 5500-EZ, plan sponsors or plan administrators are not required to sign the form. If Form 5558 is timely filed and complete, you will be granted an extension to not later than the 15th day of the 3rd month after the return/report's normal due date to file Form 5500, Form 5500-SF, or Form 5500-EZ.

**Line 3.** Enter on line 3 the due date for which you are requesting to file Form 8955-SSA. This date should not be later than the 15th day of the 3rd month after the normal due date of the return.

When using Form 5558 to request an extension of time to file Form 8955-SSA, plan sponsors or plan administrators are not required to sign the form. If Form 5558 is timely filed and complete, you will be granted an extension to not later than the 15th day of the 3rd month after the return's normal due date to file Form 8955-SSA.

## Part III. Extension of Time To File Form 5330

File one Form 5558 to request an extension of time to file Form 5330 for excise taxes with the same filing due date. For specific information on excise tax due dates, see the Instructions for Form 5330.

**How to file.** A separate Form 5558 must be used for an extension of time to file Form 5330. For example, if an employer maintains a profit-sharing plan and wishes to request extensions of time to file Form 5500 and Form 5330 for the plan, a separate Form 5558 must be used for an extension of time to file Form 5500 and an extension of time to file Form 5330.




*An extension of time to file does not extend the time to pay the tax due. Any tax due must be paid with this application for an extension of time to file Form 5330. Additionally, interest is charged on taxes not paid by the due date even if an extension of time to file is granted.*

**Note:** The IRS will no longer return stamped copies of the Form 5558 to filers who request an extension of time to file a Form 5330. Instead, you will receive a computer-generated notice to inform you if your extension is approved or denied. Because of this change, we ask you to attach a photocopy of this notice to your Form 5330.

**When to file.** To request an extension of time to file Form 5330, file Form 5558 in sufficient time for the IRS to consider and act on it before the return's normal due date.

The normal due date is the date the Form 5330 would otherwise be due, without extension.

**Line 4.** On line 4, enter the requested due date. If your application for extension of time to file Form 5330 is approved, you may be granted an extension of up to 6 months after the normal due date of Form 5330.

**Line 4a.** Indicate the section(s) for the excise tax for which you are requesting an extension.

**Line 4b.** Enter the amount of tax estimated to be due with Form 5330 and attach your payment to this form.

Make your check or money order payable to "United States Treasury." Do not send cash. On all checks or money orders, write your name, filer's identifying number (EIN or SSN), plan number, Form 5330 section number, and the tax year to which the payment applies.

**Line 5.** The IRS will grant a reasonable extension of time (not to exceed 6 months) for filing Form 5330 if you file a timely application showing that you are unable to file Form 5330 because of circumstances beyond your control. Clearly describe these circumstances. Generally, an application will be considered on the basis of your own efforts to fulfill this filing responsibility, rather than the convenience of anyone providing help in preparing the return. However, consideration will be given to any circumstances that prevent your practitioner, for reasons beyond his or her control, from filing the return by the normal due date, and to circumstances in which you are unable to get needed professional help in spite of timely efforts to do so.




*If we grant you an extension of time to file Form 5330 and later find that the statements made on this form are false or misleading, the extension will be null and void. A late filing penalty associated with the form for which you filed this extension will be charged.*

## Signature

If you are filing Form 5558 for an extension of time to file Form 5330, the Form 5558 must be signed. The person who signs this form may be an employer, a plan sponsor, a plan administrator, a disqualified person required to file Form 5330, an attorney or certified public accountant qualified to practice before the IRS, a person enrolled to practice before the IRS, or a person holding a power of attorney.

If you are filing Form 5558 for an extension of time to file Form 5500 series return/report or Form 8955-SSA, a signature is not required.

## Privacy Act and Paperwork Reduction Act Notice

We ask for the information on this form to carry out the Internal Revenue laws of the United States and the Employee Retirement Income Security Act of 1974 (ERISA). We need it to determine if you are entitled to an extension of time to file Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA, or Form 5330. You are not required to request an extension; however, if you want an extension, section 6081 requires you to provide the information. Section 6109 requires you to provide your identification number. Failure to provide this information may delay or prevent processing your request; providing false information may subject you to penalties.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential as required by section 6103.

However, section 6103 allows or requires the IRS to disclose this information to others. We may disclose to the Department of Justice for civil or criminal litigation, to the Department of Labor and the Pension Benefit Guaranty Corporation for the administration of ERISA, and to cities, states, the District of Columbia, and U.S. commonwealths or possessions to carry out their tax laws. We may also disclose the information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is 24 minutes.

If you have comments concerning the accuracy of this time estimate or suggestions for making this form simpler, we would be happy to hear from you. You can send us comments through *www.irs.gov/FormComments*. Or you can write to:

Internal Revenue Service
Tax Forms and Publications
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the tax form to this address. Instead, see *Where To File*, earlier.