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EBSA/PUBLIC DISCLOSURE

2010 NOV -9 PM 12: 52

Agfa HealthCare Corporation
100 Challenger Road
Ridgefield Park, NJ 07660

www.agfa.com

T 201-440-2500

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

October 12, 2009 ¹⁰

Top Hat Plan Exemption
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave., Suite N-1513
Washington, D.C. 20210

Re: Agfa HealthCare Corporation Deferred Compensation Plan

Dear Sir or Madam:

Pursuant to Department of Labor Regulation Section 2520.104-23, please accept this letter in satisfaction of the top hat reporting requirements with respect to the Agfa HealthCare Corporation Deferred Compensation Plan (the "Plan"). The Plan is an unfunded deferred compensation plan. Agfa HealthCare Corporation (the "Company") maintains the Plan for the purpose of providing additional benefits to a select group of management or certain highly-compensated employees.

The Company is located at 100 Challenger Road, Ridgefield Park, NJ 07660-2199. The Company's employer identification number is 20-4997964. The Plan presently covers 17 employees. The Company does not maintain any other similar plans.

Please date-stamp the enclosed copy of this letter and return it in the envelope provided. In the event that you need any further information or wish to receive a copy of the Plan documents, please contact Susan M. Szafranski, Esq. at (973) 966-8247.

Very truly yours,

A handwritten signature in black ink, appearing to read "David R. Marr".

David R. Marr

SUSAN M. SZAFRANSKI
Attorney At Law

Mail To: P.O. Box 1945 Morristown, NJ 07962
Deliver To: 200 Campus Drive Florham Park, NJ 07932
T: (973) 966-8247 F: (973) 966 1015
sszafranski@daypitney.com

November 4, 2010

DFVC Program
P.O. Box 70933
Charlotte, NC 28272-0933

Re: Agfa HealthCare Corporation Deferred Compensation Plan

Dear Sir/Madam:

Pursuant to the terms of the Department of Labor's Delinquent Filers Voluntary Compliance Program (the "DFVC Program"), published as a Federal Register notice at 60 Fed. Reg. 20874 (the "Notice"), enclosed are a signed Form 5500 and the appropriate statement under Department of Labor Regulation Section 2520.104-23(b) with respect to the Agfa HealthCare Corporation Deferred Compensation Plan (the "Plan"). The Plan is sponsored by Agfa HealthCare Corporation (the "Company").

Pursuant to Section 4 of the Notice, only the required items of Forms 5500 were completed for the Plan. The Plan is eligible for the DFVC Program pursuant to Section 2 of the Notice. The Plan Administrator has not been notified in writing that the Department of Labor ("DOL") intends to assess a civil penalty under Section 502(c)(2) of ERISA for failure to file a timely report, and has not otherwise been notified in writing by the DOL of a failure to file a timely annual report under Title I of ERISA.

DOL Reg. § 2520.104-23(a) provides that top hat plans are not required to file Form 5500, provided that the plan sponsor files a statement with the DOL within 120 days after adoption of the plan. Such statement must satisfy the requirements of DOL Reg. § 2520.104-23(b). Pursuant to Section 4 of the Notice, a top hat plan may elect to file a statement as described in DOL Reg. § 2520.104-23 as a condition of relief from the annual reporting requirement in lieu of filing any past due annual report and paying otherwise applicable civil penalties.

In accordance with Section 4.01(c) of the Notice, enclosed is a check in the amount of \$750, which represents the applicable penalty amount. The Company, having elected compliance with the alternative method of compliance prescribed in DOL Reg. § 2520.104-23, is considered as having elected the alternative method of compliance for all subsequent plan years. The Company acknowledges that acceptance by the DOL of this filing and penalty payment made pursuant to the DFVC Program does not represent a determination by the DOL as to the

DFVC Program
November 4, 2010
Page 2

status of the arrangement as a plan of a particular type under Title 1 of ERISA or a determination by the DOL that the provisions of DOL Reg. § 2520.104-23 have been satisfied.

If you have any questions regarding this matter, please do not hesitate contact me.

Very truly yours,


Susan M. Szafranski

cc: David R. Marr
U.S. Department of Labor (EBSA)

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 under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(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
1210-0089

2008

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning _____ and ending _____

- A** This return/report is for: (1) a multiemployer plan; (3) a multiple-employer plan; or
 (2) a single-employer plan (other than a multiple-employer plan); (4) a DFE (specify) _____
- 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).

Part II Basic Plan Information — enter all requested information.

1a Name of plan
AGFA HEALTHCARE CORPORATION
DEFERRED COMPENSATION PLAN

1b Three-digit plan number (PN) ▶ 888

1c Effective date of plan (mo., day, yr.)

2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
HEALTHCARE CORPORATION

2b Employer Identification Number (EIN)
20-4997964

2c Sponsor's telephone number
201-373-4281

2d Business code (see instructions)

100 CHALLENGER ROAD

RIDGEFIELD PARK

NJ 07660-2199

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.

SIGN HERE

David R. Marr

10/12/09
Date

DAVID R. MARR

Type or print name of individual signing as plan administrator

SIGN HERE

David R. Marr

10/12/09
Date

DAVID R. MARR

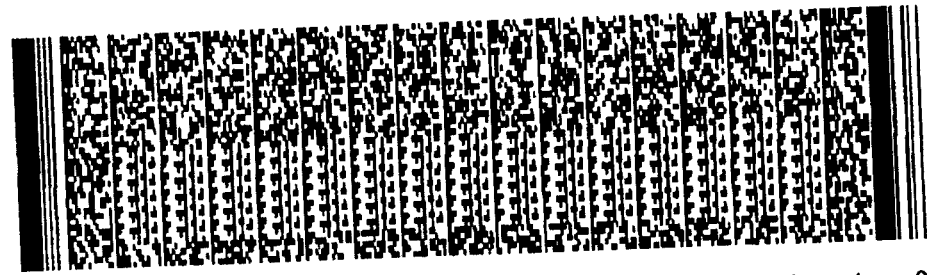
Type or print name of individual signing as employer, plan sponsor or DFE

Signature of employer/plan sponsor/DFE

v11.3

Form 5500 (2008)

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



3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
HEALTHCARE CORPORATION

3b Administrator's EIN
20-4997964

3c Administrator's telephone number
201-373-4281

100 CHALLENGER ROAD

RIDGEFIELD PARK NJ 07660-2199

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:

b EIN

c PN

a Sponsor's name

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

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

7a

a Active participants

7b

b Retired or separated participants receiving benefits

7c

c Other retired or separated participants entitled to future benefits

7d

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

7e

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

7f

f Total. Add lines 7d and 7e

7g

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

7h

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

7i

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)

7j

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):

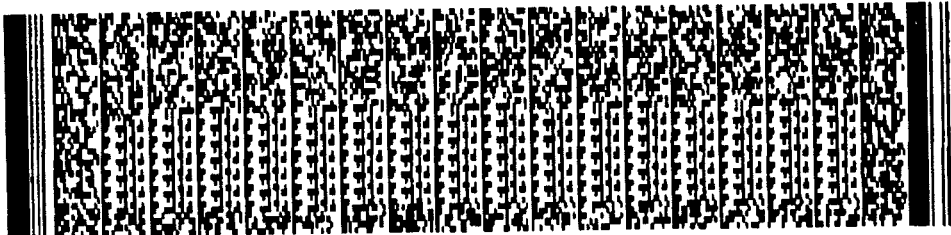
b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

9a Plan funding arrangement (check all that apply)

- (1) 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) 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) **R** (Retirement Plan Information)
- (2) **B** (Actuarial Information)
- (3) **E** (ESOP Annual Information)
- (4) **SSA** (Separated Vested Participant Information)

b Financial Schedules

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

