

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
1210-0099

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.

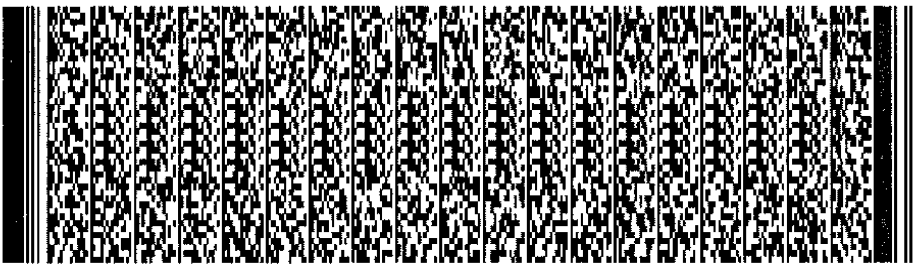
1a Name of plan RETIREMENT PLAN FOR EMPLOYEES OF CH EMICAL LEAMAN CORP AND AFFILIATED C ORP	1b Three-digit plan number (PN) ▶ 002
	1c Effective date of plan (mo., day, yr.) 01/01/1976
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) QUALITY DISTRIBUTION, INC. 4041 PARK OAKS BLVD SUITE 200 TAMPA FL 33610-9501	2b Employer Identification Number (EIN) 59-3239073
	2c Sponsor's telephone number 813-569-7355
	2d Business code (see instructions) 551112

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 	10/12/09	Dennis R Copeland
Signature of plan administrator	Date	Type or print name of individual signing as plan administrator
SIGN HERE 	10/12/09	Dennis R Copeland
Signature of employer/plan sponsor/DFE	Date	Type or print name of individual signing as employer, plan sponsor or DFE

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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	929
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	33
b Retired or separated participants receiving benefits	7b	414
c Other retired or separated participants entitled to future benefits	7c	452
d Subtotal. Add lines 7a, 7b, and 7c	7d	899
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	7e	12
f Total. Add lines 7d and 7e	7f	911
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	
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	17

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

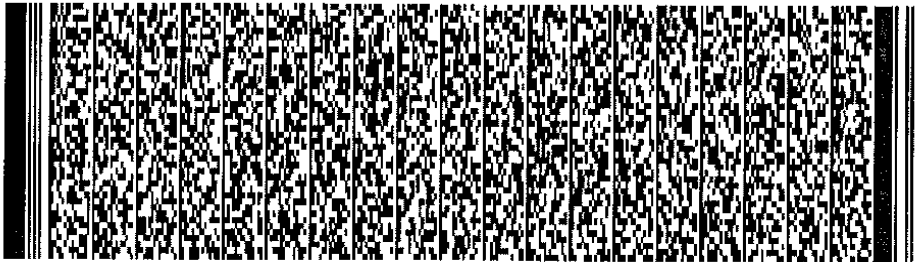
- a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): 1G 1I
- b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable 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(i) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

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



0 2 0 8 7 7 0 2 0 Q



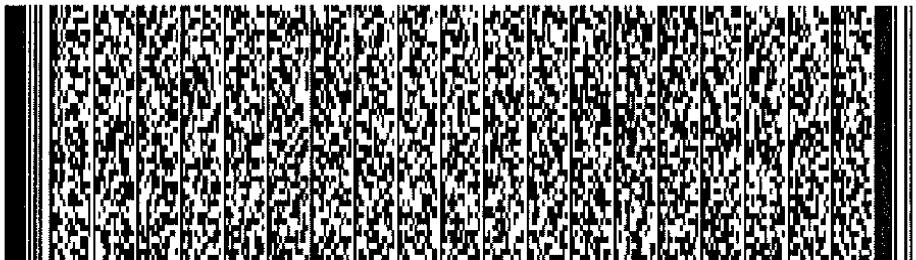
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

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) 1 A (Insurance Information)
- (4) C (Service Provider Information)
- (5) D (DFE/Participating Plan Information)
- (6) G (Financial Transaction Schedules)



0 2 0 8 7 7 0 3 0 R



**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 _____ and ending _____

A Name of plan RETIREMENT PLAN FOR EMPLOYEES OF CHEMICAL LEAMAN CORP AND AF	B Three-digit plan number ▶	002
C Plan sponsor's name as shown on line 2a of Form 5500 QUALITY DISTRIBUTION, INC.	D Employer Identification Number 59-3239073	

Part II 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

PRINCIPAL 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
42-0127290	61271	6-11346	911	01/01/2008	12/31/2008

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
23713	4484

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