Missing Participant Information

Schedule MP
(to forms 501 and 602)
Approved OMB 1212-0036
Expires 2/28/2017

DO NOT SEND PAYMENT WITH THIS FORM.
SEND PAYMENT TO PBGC'S LOCKBOX WITH MISSING PARTICIPANT PAYMENT VOUCHER.

File this form (with Form 501 or Form 602) if the plan purchased irrevocable commitments for one or more Missing Participants or is paying amounts to PBGC for one or more Missing Participants.

PART I. PLAN IDENTIFICATION INFORMATION

Check here if you previously filed a Schedule MP for this plan: ☐ **If checked, provide date(s) of filing(s):**

1a Plan Name	**1b** 9-digit employer identification number (EIN)
	1c 3-digit plan number (PN)
	1d 8-digit PBGC Case #

PART II. MISSING PARTICIPANT INFORMATION

2a Name and address (mailing or Internet) of commercial locator service(s) used		
	(1) Relating to this filing	(2) Total for all filings
3a Number of Missing Participants for whom irrevocable commitments were purchased		
3b Number of Missing Participants for whom amounts are due to PBGC		
3c Deemed distribution date (see definition on page 2 of instructions)	(MM/DD/YYYY)	

PART III. AMOUNTS DUE TO PBGC (Sum of the amounts on all Attachments B)

	(1) Relating to this filing	(2) Total for all filings
4a Total amount of designated benefits	$	$
4b Total of other amounts due for Missing Participants	$	$
4c Total amount due to PBGC (line 4a + line 4b)	$	$
4d Date designated benefits in 4a sent to PBGC	(MM/DD/YYYY)	
4e Is date in 4d more than 90 days after date in 3c? If "Yes," interest will be assessed by PBGC. See instructions.	☐ Yes	☐ No

PART IV. PLAN ADMINISTRATOR CERTIFICATION

I, the Plan Administrator, certify that to the best of my knowledge and belief (1) I have met the diligent search requirements of 29 CFR § 4050.4 and (2) the information contained in this filing is true, correct and complete. **In making this certification, I recognize that knowingly and willfully making false, fictitious, or fraudulent statements to the PBGC is punishable under 18 U.S.C. § 1001.**

Plan Administrator's company's name and address (Address should include room or suite no.)	Telephone Number
	E-mail address (optional)
Plan Administrator's signature Date	Print or type name of individual who signs

PART V. ENROLLED ACTUARY CERTIFICATION

NOTE: Not required if all benefits for all Missing Participants are distributed through the purchase of irrevocable commitments from an insurer.

I, the Enrolled Actuary, certify that to the best of my knowledge and belief (1) the actuarial information contained in this filing is true, correct, and complete and (2) the designated benefits and/or other amounts payable for Missing Participants have been calculated in accordance with applicable provisions of ERISA and the Internal Revenue Code and regulations promulgated thereunder. **In making this certification, I recognize that knowingly and willfully making false, fictitious, or fraudulent statements to the PBGC is punishable under 18 U.S.C. § 1001.**

Enrolled Actuary's company name and address (Address should include room or suite no.)	Enrolled Actuary's Name (Print or type)
	Enrollment Number
	Telephone Number
Enrolled Actuary's signature Date	E-mail address (optional)

Missing Participant Annuity Purchase Information

Attachment A
(to Schedule MP)
Approved OMB 1212-0036
Expires 2/28/2017

Attach Attachment A to (or submit the required information on a separate page or pages with) Schedule MP if the plan purchased irrevocable commitments from an insurer for one or more Missing Participants. If requested information is not available, write "N/A" in the space provided. If any Missing Participant's annuity certificate number is not available, report it when it becomes available. **If irrevocable commitments were purchased from more than one insurer, complete a separate Attachment A for each insurer.**

This Attachment A is Number _____ of _____ total Attachments A.

PART I. PLAN IDENTIFICATION INFORMATION

Check here if you previously filed an Attachment A for this plan: ☐

1a Plan Name	**1b** 9-digit employer identification number (EIN)
	1c 3-digit plan number (PN)
	1d 8-digit PBGC Case #

PART II. INSURANCE COMPANY INFORMATION

2a Name and address of Insurer (Address should include room or suite no.)	**2b** Insurance company contact name
	2c Telephone number
	2d Policy number

PART III. ANNUITIZED MISSING PARTICIPANT INFORMATION

Missing Participant full name (last, first, middle)	Spouse or Beneficiary full name (last, first, middle)
Social Security Number	Social Security Number
Date of Birth (MM/DD/YYYY)	Date of Birth (MM/DD/YYYY)
Certificate Number	
Monthly Benefit (see instructions) $	
Missing Participant full name (last, first, middle)	Spouse or Beneficiary full name (last, first, middle)
Social Security Number	Social Security Number
Date of Birth (MM/DD/YYYY)	Date of Birth (MM/DD/YYYY)
Certificate Number	
Monthly Benefit (see instructions) $	
Missing Participant full name (last, first, middle)	Spouse or Beneficiary full name (last, first, middle)
Social Security Number	Social Security Number
Date of Birth (MM/DD/YYYY)	Date of Birth (MM/DD/YYYY)
Certificate Number	
Monthly Benefit (see instructions) $	
Missing Participant full name (last, first, middle)	Spouse or Beneficiary full name (last, first, middle)
Social Security Number	Social Security Number
Date of Birth (MM/DD/YYYY)	Date of Birth (MM/DD/YYYY)
Certificate Number	
Monthly Benefit (see instructions) $	

Missing Participant Individual Information

Attachment B
(to Schedule MP)
Approved OMB 1212-0036
Expires 2/28/2017

File a separate Attachment B for each Missing Participant for whom an amount is due to PBGC. If requested information is not available, write "N/A" in the space provided.

This Attachment B is Number _____ of _____ total Attachments B.

PART I. PLAN IDENTIFICATION INFORMATION

1a Plan Name	**1b** 9-digit employer identification number (EIN)
	1c 3-digit plan number (PN)
	1d 8-digit PBGC Case #

PART II. IDENTIFICATION OF MISSING PARTICIPANT

Check here if you previously filed an Attachment B for this individual: ☐

2a Missing Participant name (last, first, middle)	**2b** Social Security Number
2c Last-known address	**2d** Date of birth (MM/DD/YYYY)
2e Other name(s) ever used (if known)	**2f** Sex ☐ Male ☐ Female

2g Status (check one) ☐ 1. Participant ☐ 2. Spouse ☐ 3. Alternate payee (Attach copy of QDRO) ☐ 4. Other beneficiary

PART III. AMOUNTS DUE TO PBGC

	(1) Relating to this filing	(2) Total for all filings
3a Category of Designated Benefit (Check 1, 2, 3, or 4)		
☐ 1. **Mandatory lump sum** (automatic cashout using plan cashout assumptions and limits).		
☐ 2. **De minimis lump sum** (using PBGC Missing Participant lump sum assumptions).		
☐ 3. **No lump sum** (annuity only). Check (a) or (b) below.		
☐ (a). An adjustment (loading) for expenses of $300 is included because the designated benefit without the loading is greater than $5,000.		
☐ (b). An adjustment (loading) for expenses of $300 is <u>not</u> included because the designated benefit without the loading is $5,000 or less.		
☐ 4. **Elective lump sum.** Check (a) or (b) below.		
☐ (a). An adjustment (loading) for expenses of $300 is included because the designated benefit amount was determined using the methodology of 29 CFR § 4050.5(a)(3) <u>and</u> the designated benefit amount without the loading is greater than $5,000.		
☐ (b). An adjustment (loading) for expenses of $300 is <u>not</u> included because EITHER (1) the designated benefit amount was determined using the methodology of 29 CFR § 4050.5(a)(1) <u>OR</u> (2) the designated benefit amount was determined using the methodology of 29 CFR § 4050.5(a)(3) <u>and</u> the designated benefit amount without the loading is $5,000 or less.		
3b Amount of Designated Benefit	**$**	**$**

Missing Participant's Social Security No. _____

3b **(continued)** Is any part of the Missing Participant's designated benefit amount attributable to mandatory employee contributions? If "Yes" complete (1)-(3) below (if "No," go to 3c).	☐ Yes	☐ No
	(1) Relating to this filing	(2) Total for all filings
(1) Mandatory employee contributions that fund a portion of the Missing Participant's accrued benefit under the plan,	$	$
(2) Interest credited on those contributions to the deemed distribution date	$	$
(3) The total of (1) and (2). **The amount in 3b on p. 1 must not be less than this amount.**	$	$
3c Other amounts due to PBGC, if any. Complete (1) if any additional amount is due to PBGC for voluntary employee contributions. Complete (2) if any amount is due to PBGC for the Missing Participant's share of residual assets.		
(1) Voluntary employee contributions and earnings		
(a) Voluntary employee contributions held in a separate account.	$	$
(b) Earnings credited on contributions in (a) to the date sent to PBGC.	$	$
(c) Total of (a) and (b).	$	$
(d) If the amount entered in (1)(c) is not zero, enter the date voluntary contributions sent to PBGC.	(MM/DD/YYYY)	
(2) Residual assets and earnings		
(a) The amount, if any, of residual assets due to PBGC based on a Missing Participant's share of residual assets.	$	$
(b) Earnings on residual assets to the date you pay PBGC.	$	$
(c) Total of (a) and (b).	$	$
(d) If the amount entered in (2)(c) is not zero, enter the date residual assets sent to PBGC.	(MM/DD/YYYY)	
(3) Total other amounts due, if any, to PBGC (line (1)(c) + line (2)(c)).	$	$
3d Total amount due to PBGC (line 3b (on p. 1) + line 3c(3)) **Pay this amount**	$	$

Missing Participant's Social Security No. _____

Complete item 4 or item 5 or item 6 below (complete only *one*):

- **For a Missing Participant who is a *participant* and whose benefit was not in pay status as of the deemed distribution date → Complete item 4**
- **For a Missing Participant who is a *beneficiary* (including a spouse or alternate payee) and whose benefit was not in pay status as of the deemed distribution date → Complete item 5**
- **For a Missing Participant whose benefit was in pay status as of the deemed distribution → Complete item 6**

After completing item 4, item 5 or item 6, go to item 7.

4	For a participant who is missing and whose benefit was not in pay status as of the deemed distribution date, provide the following information.	
4a	Participant's earliest retirement date (or the deemed distribution date, if later).	(MM/DD/YYYY)
4b	Last-known spouse's full name (last, first, middle)	Spouse's Social Security Number

If you checked Category 1 in item 3 above, go to item 7.

4c	Did the participant and last-known spouse waive the QPSA provided under the plan? If "Yes," attach waiver.	☐ Yes ☐ No ☐ N/A
4d	Spouse's earliest possible QPSA annuity starting date under the plan (or deemed distribution date, if later). If the QPSA is payable immediately upon the participant's death, enter the deemed distribution date.	(MM/DD/YYYY)
4e	Automatic annuity form of retirement benefit that would be payable with respect to the participant under the plan. **Note:** Provide the benefit forms for both married and unmarried participants regardless of the participant's last-known marital status.	

(1) **MARRIED PARTICIPANT**

Code from table on page 12 in instructions:

If you entered:	**Provide this information:**	
Code 5 or 6	Survivor percentage:	%
Code 2, 3 or 6	Number of monthly payments in period certain:	
Code 4	Temporary annuity period:	
Code 10	Other benefit form. Describe the form:	

(2) **UNMARRIED PARTICIPANT**

Code from table on page 12 in instructions:

If you entered:	**Provide this information:**	
Code 5 or 6	Survivor percentage:	%
Code 2, 3 or 6	Number of monthly payments in period certain:	
Code 4	Temporary annuity period:	
Code 10	Other benefit form. Describe the form:	

5	For a beneficiary (including a participant's spouse or alternate payee) who is missing and whose benefit was not in pay status as of the deemed distribution date, complete the following:	
5a	Form of benefit to which the beneficiary or alternate payee is entitled.	Code from table on page 12 in instructions:

If you entered:	**Provide this information:**	
Code 5 or 6	Survivor percentage:	%
Code 2, 3 or 6	Number of monthly payments in period certain:	
Code 4	Temporary annuity period:	
Code 10	Other benefit form. Describe the form:	

5b	Earliest date the beneficiary or alternate payee could commence receiving benefits (or the deemed distribution date, if later).	(MM/DD/YYYY)

Missing Participant's Social Security No. _____

6	For a participant or a beneficiary (including a participant's spouse or alternate payee) who is missing and whose benefit was in pay status as of the deemed distribution date, complete the following:	
6a	Form of benefit that was in pay status. (Attach a copy of form election, if any.)	Code from table on page 12 in instructions:

If you entered:	**Provide this information:**	
Code 5 or 6	Survivor percentage:	%
Code 2, 3 or 6	Number of monthly payments in period certain remaining as of deemed distribution date:	
Code 4	Temporary annuity period remaining as of the deemed distribution date (in months):	
Code 7 or 8	Fixed sum remaining as of the deemed distribution date:	$
Code 10	Other benefit form. Describe the form:	

And provide (as applicable):

Date of first missed monthly payment:	(MM/DD/YYYY)
Amount of first missed monthly payment:	$
Plan interest rate for missed payments:	%
Payments that were due before the deemed distribution date but that were not made, with interest through the deemed distribution date (the amount entered here must be included in item 3b above; it is part of designated benefit amount)	$

6b	Name of Missing Participant's beneficiaries, if any (last, first, middle). (Attach a copy of beneficiary designation form, if any.)	Relationship (e.g., spouse, child, estate)
		Social Security Number

7	Attached Documents. Check all document(s) which are attached:	
a	Waiver of Qualified Pre-retirement Survivor Annuity (QPSA)	☐
b	Election of optional benefit form	☐
c	Designation(s) of beneficiary	☐
d	Qualified Domestic Relations Order(s) (QDROs)	☐

Missing Participant Payment Voucher

Payment Voucher

(to Schedule MP)

Approved OMB 1212-0036
Expires 2/28/2017

Do not send Schedule MP or attachments with this payment voucher.
Send Schedule MP and attachments to PBGC at the address listed in the instructions for where to file.

Use this form if any amount is paid to PBGC for Missing Participants. Send this form (with payment by check or wire transfer information) to the lockbox address below.

PART I. PLAN IDENTIFICATION INFORMATION

1a Plan Name	**1b** 9-digit employer identification number (EIN)
	1c 3-digit plan number (PN)
	1d 8-digit PBGC Case #

PART II. PLAN ADMINISTRATOR CONTACT

2a Plan Administrator's name	**2b** Telephone number
	2c E-mail address (optional)

PART III. AMOUNTS PAID TO PBGC

3a Amount enclosed or wired. (Make check payable to Pension Benefit Guaranty Corp.) **Note: The amount enclosed or wired must equal the amount in column (1) of item 4c of Schedule MP**	**$** ☐ Check ☐ Wire transfer
3b Amount Enclosed or wired for interest assessed by PBGC, if applicable.	**$**
3c Check number	
3d Date Schedule MP was sent to PBGC	(MM/DD/YYYY)

If you are using the U.S. Postal Service, send payment (with this voucher) to:

Pension Benefit Guaranty Corporation
P.O. Box 979114
St. Louis, MO 63197-9000

If you are using a delivery service other than the U.S. Postal Service, send payment (with this voucher) to:

PBGC Missing Participants Box 979114
U.S. Bank Government Lockbox
1005 Convention Plaza
SL-MO-C2GL
St. Louis, MO 63101

If you are using a wire transfer, send wire transfer to:

US BANK
Routing: 081000210
Account: 152310875843
Beneficiary: PBGC
Payment ID line: (MP, the plan's EIN/PN, and the standard termination case number)

Please use the following format: "MP, EIN/PN: XX-XXXXXXX/XXX, CN: XXXXXXXX."