



Distress Termination Notice of Intent to Terminate

PBGC Form 600

Approved OMB 1212-0036
Expires 09/30/2007

PART I. IDENTIFYING INFORMATION

1a Plan Name	1b Plan effective date (mo., day, yr.)
	1c Last day of plan year
2a Contributing Sponsor's name and address (Address should include room or suite no.)	Sponsor's telephone number
	2b 9-digit employer identification number (EIN)
	3-digit plan number (PN)
2c If you used a different EIN or PN for this contributing sponsor/plan in previous filings with the PBGC, also show the number(s) previously reported.	2d Contributing sponsor's tax year end (mo., day, yr.)
	2e 6-digit business code
3a Plan Administrator's name and address (if same as 2a, enter "same") (Address should include room or suite no.)	Plan Administrator's telephone number
	E-mail address (optional)
3b Name and address of person to be contacted for more information (if same as 3a, enter "same"). (Address should include room or suite no.)	Telephone number
	E-mail address (optional)

PART II. GENERAL PLAN INFORMATION

4 Proposed termination date	(mo., day, yr.)	
5 Estimated number of plan participants as of the proposed termination date		
a Active participants:		
(i) Fully vested	(i)	
(ii) Partially vested	(ii)	
(iii) Nonvested	(iii)	
(iv) Total active participants [add a(i) through (iii)]	(iv)	
b Retirees or beneficiaries receiving benefits	5b	
c Separated vested participants entitled to benefits	5c	
d Total [add a(iv) through c]	5d	
6 Changes in contributing sponsor associated with plan termination (check all that apply):		
a No change	6a	
b Reorganization as part of bankruptcy or similar proceeding	6b	
c Merger of existing subsidiaries or divisions not involving bankruptcy	6c	
d Sale or closing of subsidiaries or divisions not involving bankruptcy	6d	
e Acquisition <u>by</u> another business	6e	
f Acquisition <u>of</u> another business	6f	
g Liquidation	6g	

<p>7 Intention concerning expected pension coverage for currently employed participants covered under the terminated plan (check all that apply):</p> <p>a No new plan</p> <p>b New or existing defined benefit plan</p> <p>c New or existing profit-sharing plan</p> <p>d New or existing 401(k) plan</p> <p>e Other new or existing plan. Specify:</p>			
	7a		
	7b		
	7c		
	7d		
	7e		
8a Is there more than one contributing sponsor?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b If "Yes," is this a multiple-employer plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
9a Is the contributing sponsor(s) a member of a controlled group?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b If you checked "Yes" in 8a or 9a, attach a statement identifying each contributing sponsor and each member of the contributing sponsor's controlled group as of the proposed termination date and the distress test each entity expects to meet.			
10a Has there been a change in the composition of a contributing sponsor's controlled group within the 5-year period prior to the proposed termination date?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	10b If "Yes," attach a statement that describes the transaction(s).		
11a Has the contributing sponsor(s) filed, or had filed against it, a petition seeking reorganization in bankruptcy under Chapter 11, liquidation in bankruptcy under Chapter 7, or reorganization or liquidation in a similar proceeding under the laws of a state or a political subdivision of a state?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b If you checked "Yes" in 11a, are the proceedings still ongoing?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
c If "Yes," attach a copy of the petition showing the court docket number. If "No," attach a copy of the order dismissing or otherwise resolving the proceedings.	For reorganization under Chapter 11 or similar state proceeding, complete item 11d.		
d Has the bankruptcy court been requested to approve the termination of the plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
e If "Yes":			
(i) Enter the date of request to the court	(mo., day, yr.)		
(ii) Enter the date documents were submitted to PBGC	(mo., day, yr.)		
12a Are all eligible participants/beneficiaries, who are entitled to and have applied for benefits, receiving such monthly benefits from the plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
12b If "No," attach a statement as to the reason for non-payment, including the number of participants/beneficiaries and total monthly benefits not being paid.			
13a Are the plan assets expected to be sufficient to continue to pay all benefits when due during the next 180 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	13b If "No," attach an explanation.		
14a Are any participants/beneficiaries receiving benefits in excess of estimated Title IV benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
14b If "Yes," are they scheduled to be reduced to the estimated Title IV level as of the proposed termination date?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
15 Attach copies of the following documents:			
a All plan documents, including all amendments within the last five years;			
b Trust documents and/or insurance contracts;			
c Most recent financial statement of plan assets;			
d Collective bargaining agreements relating to the plan;			
e IRS determination letter(s);			
f Most recent plan actuarial report; and			
g Form 5500, Schedules B and SSA (last three years).			
16 Location of plan records (Address should include room or suite no.)	Type of Record		
	Telephone number		

PART III. PLAN ADMINISTRATOR CERTIFICATION

I, the Plan Administrator, certify that, to the best of my knowledge and belief: (1) I am implementing the termination of the plan in accordance with all applicable laws and regulations; and (2) the information contained in this filing and made available to the Enrolled Actuary 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 signature

Date

Name and title of Plan Administrator



Distress Termination Designation of Representative

PBGC Schedule REP-D

(PBGC Form 600)
Approved OMB 1212-0036
Expires 09/30/2007

PART I. IDENTIFYING INFORMATION

1 Plan Name	
2 Employer identification and plan numbers	9-digit employer identification number (EIN)
	3-digit plan number (PN)
3 Plan Administrator's name and address (Address should include room or suite no.)	Plan Administrator's telephone number
	E-mail address (optional)

PART II. DESIGNATION OF REPRESENTATIVE(S)

4 I, _____, Plan Administrator of the above-named pension plan, hereby appoint the following representative(s) to act on my behalf before the Pension Benefit Guaranty Corporation on all matters (other than those specifically excluded below) relating to the termination of the above-named pension plan:

5a Representative's name and address (Address should include room or suite no.)	Telephone number
	E-mail address (optional)
5b Representative's name and address (Address should include room or suite no.)	Telephone number
	E-mail address (optional)

6 Matters excluded (list any specific acts with respect to the plan termination that you are excluding from the acts otherwise authorized in this designation):

PART III. RETENTION / REVOCATION OF PRIOR DESIGNATION(S)

7a Have you filed any prior designation(s) of representative(s) for this termination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7b If "Yes," do you want any such prior designation(s) of representative(s) to remain in effect? (Attach a copy of all prior designations that are to remain in effect.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART IV. SIGNATURE OF PLAN ADMINISTRATOR

NOTE: The PBGC will NOT accept unsigned designations. If the Plan Administrator is a board (or similar group) composed of employer and employee representatives, at least one employer representative and one employee representative must sign this form. If the Plan Administrator is other than an individual or a board, this form must be signed by an officer of the Plan Administrator who has the authority to do so.

In executing this document, I certify that the foregoing is true and correct, and recognize that knowingly and willfully making false, fictitious, or fraudulent statements to the PBGC is punishable under 18 U.S.C. 1001.

Signature	Date	Name and title
Signature	Date	Name and title



Distress Termination Notice Single-Employer Plan Termination

PBGC Form 601

Approved OMB 1212-0036
Expires 09/30/2007

PART I. IDENTIFYING INFORMATION

1	Plan Name	
2	Contributing sponsor	
3	Employer identification and plan numbers	9-digit employer identification number (EIN) 3-digit plan number (PN)
4	PBGC Case Number	8-digit Case #

PART II. SPECIFIC PLAN INFORMATION

5a	Proposed termination date	(mo., day, yr.)
5b	Proposed termination date stated in notice of intent to terminate (if different from 5a)	(mo., day, yr.)
6a	Earliest date notices of intent to terminate issued to affected parties	(mo., day, yr.)
6b	Latest date notices of intent to terminate issued to affected parties (other than PBGC)	(mo., day, yr.)
7a	Does each contributing sponsor and each member of a contributing sponsor's controlled group meet one of the distress tests described in ERISA § 4041(c)(2)(B) and 29 CFR § 4041.41(c)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7b	Attach a statement identifying each contributing sponsor and each controlled group member and the distress test met by each. Also attach the information to demonstrate that each contributing sponsor and controlled group member meets the distress test(s) identified.	
8a	Has a formal challenge to the termination been initiated under an existing collective bargaining agreement?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8b	If "Yes," attach a copy of the formal challenge and a statement describing the challenge.	
9	For plans that were paying benefits in excess of Title IV benefits, have the benefits of participants/beneficiaries in pay status been reduced to the estimated Title IV benefits pursuant to 29 CFR Part 2022, Subpart D?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
10	Has the plan ever required employee contributions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11a	Have you filed or will you file with the Internal Revenue Service an application for a determination letter on the termination of this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11b	If "Yes," enter the filing date:	(mo., day, yr.)
12a	Has the Internal Revenue Service granted any minimum funding waiver(s) for this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12b	If "Yes," attach (1) copies of all waiver ruling letters and (2) a schedule showing the total amount waived for each plan year and the remaining amortized amount of the waiver.	
13a	Are there any requests for minimum funding waiver(s) pending before the IRS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13b	If "Yes," attach (1) copies of all applications including cover letters and exhibits and (2) a schedule showing for each plan year the pending waiver amount.	
14a	Are there outstanding employer contributions owed to the plan exclusive of amounts described in 12 and 13?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14b	If "Yes," attach a schedule showing for each plan year the amount of outstanding employer contributions owed.	

PART III. PLAN ADMINISTRATOR CERTIFICATION

I, the Plan Administrator, certify that, to the best of my knowledge and belief: (1) the information contained in this filing is true, correct, and complete; and (2) the information provided to the Enrolled Actuary 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 signature

Date

Name and title of Plan Administrator



Distress Termination Enrolled Actuary Certification

PBGC Schedule EA-D

(PBGC Form 601)
Approved OMB 1212-0036
Expires 09/30/2007

Plan Name	9-digit employer identification number (EIN)
	3-digit plan number (PN)

PART I. SUFFICIENCY LEVEL AS OF PROPOSED TERMINATION DATE

1 As of the proposed termination date, is the value of plan assets available to pay for plan benefits, when allocated in accordance with section 4044 of ERISA...	
a ...less than the value of all benefits guaranteed by the PBGC under section 4022(a) and (b) of ERISA?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b ...equal to or greater than the value of guaranteed benefits, but less than the value of benefit liabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c ...equal to or greater than the value of benefit liabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you checked "Yes" in 1a, complete the rest of Part I and complete Part III. Do not complete Part II. If you checked "No" in 1a, complete the rest of Part I, Part II, and Part III.	
2 Estimated value of plan assets available to pay for plan benefits, determined as of the proposed termination date:	
a Estimated fair market value of plan assets (excluding value of contributions owed to the plan)	\$
b Estimated total contributions owed to the plan	\$
c Estimated collectible value of 2b	\$
d Estimated value of total plan assets (sum of a and c)	\$
3 Estimated value of Title IV benefits as of the proposed termination date	\$
4 Estimated present value of all benefit liabilities as of the proposed termination date	\$

PART II. SUFFICIENCY LEVEL AS OF PROPOSED DISTRIBUTION DATE

5 Proposed distribution date	(mo., day, yr.)
6 As of the proposed distribution date, do you project that the plan will have sufficient assets available to pay for plan benefits, when allocated in accordance with section 4044 of ERISA, to provide...	
a ...all benefits guaranteed by the PBGC under section 4022(a) and (b) of ERISA, but not all benefit liabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b ...all benefit liabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART III. ENROLLED ACTUARY CERTIFICATION

<p>I, the Enrolled Actuary, certify that: (1) I have reviewed all relevant plan documents, plan and participant data, and the method used to value the plan assets; (2) I have applied all relevant provisions of ERISA and the Internal Revenue Code and regulations promulgated thereunder; (3) to the best of my knowledge and belief, the information contained in this schedule is true, correct, and complete; and (4) to the best of my knowledge and belief, the plan's assets and benefits have been valued in accordance with Title IV and PBGC regulations; and the value of the plan's assets, when allocated in accordance with the PBGC's regulation on allocation of assets (29 CFR Part 4044), is sufficient (as of the proposed termination date) to provide plan benefits as indicated (check one):</p> <p>In making this certification, I recognize that knowingly and willfully making false, fictitious, or fraudulent statements to the PBGC in punishable under 18 U.S.C. 1001.</p> <p style="margin-left: 20px;">Enrolled Actuary's company name and address (Address should include room or suite no.)</p>	<div style="background-color: #cccccc; height: 80px; margin-bottom: 5px;"></div> <input type="checkbox"/> Insufficient for guaranteed benefits <input type="checkbox"/> Sufficient for guaranteed benefits but not for benefit liabilities <input type="checkbox"/> Sufficient for benefit liabilities
Enrolled Actuary's signature	Date
	Enrollment Number
	Telephone Number
	E-mail address (optional)



Post-Distribution Certification for Distress Termination

PBGC Form 602

Approved OMB 1212-0036
Expires 09/30/2007

PART I. IDENTIFYING INFORMATION

1 Plan Name	
2 Employer identification and plan numbers	9-digit employer identification number (EIN)
	3-digit plan number (PN)
3 PBGC case number	8-digit Case #
4a Last distribution date	(mo., day, yr.)
4b Date of receipt of IRS determination letter	(mo., day, yr.)
5 Latest date notices of benefit distribution issued to participants or beneficiaries	(mo., day, yr.)
6 Were participants and beneficiaries provided with the name and address of the insurer(s) no later than 45 days before the date of distribution? (See page 21 of instructions.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
7 Were you able to locate all participants and beneficiaries? If "No," see instructions.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8a Has a copy of the annuity contract, certificate, or written notice been provided to each participant and beneficiary receiving benefits in the form of an irrevocable commitment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8b If "Yes," enter date, or latest date, annuity contracts, certificates, or written notices were provided to participants and beneficiaries:	(mo., day, yr.)
9 Insurer(s) full office name of record), if any, from whom annuity contracts have been purchased. (Address should include room or suite no.)	Annuity Contract Number(s)
10 Location of plan records (Address should include room or suite no.)	Telephone number

11 Summary of distribution of plan benefits		
Form	# of Participants or Beneficiaries	Total Value
a Annuities		\$
b Lump sums (including direct transfers and distributions to participants and beneficiaries)		
• Consensual		\$
• Nonconsensual		\$
c Designated benefits paid to PBGC for Missing Participants		\$
d No Distribution		
e TOTAL		\$

PART II. PLAN ADMINISTRATOR CERTIFICATION

I, the Plan Administrator, certify that: (1) to the best of my knowledge and belief, benefits payable with respect to participants have been calculated and valued correctly in accordance with applicable provisions of ERISA and the regulations thereunder; (2) to the best of my knowledge and belief, all (check one) guaranteed benefits OR benefit liabilities under the plan have been satisfied; (3) to the best of my knowledge and belief, the information contained in this filing is true, correct, and complete, and (4) I am aware that records supporting the calculation and valuation of benefits and assets must be kept at least six years after the date this post-distribution certification is filed. 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 name and company (Address should include room or suite no.)	Telephone number
	Name of Plan Administrator
	Title of Plan Administrator
Plan Administrator's signature	Date