



# Missing Participants Program Plan Information for Defined Contribution Plans

Form MP-200  
Approved OMB 1212-0069  
Expires 1/31/2021XXXX

Amended Filing

**Clear Form**

## Part I — General Information

### 1 Plan information

a Plan name \_\_\_\_\_

b Employer identification number/plan number \_\_\_\_ - \_\_\_\_ / \_\_\_\_ c 8-digit PBGC Case # \_\_\_\_\_

d Plan contact

(1) Name \_\_\_\_\_ (2) Company \_\_\_\_\_

(3) Street address \_\_\_\_\_

(4) City \_\_\_\_\_ (5) State \_\_\_\_\_ (6) Zip \_\_\_\_\_ -

(7) Telephone \_\_\_\_ - \_\_\_\_ - \_\_\_\_ ext \_\_\_\_\_ (8) email \_\_\_\_\_

e Is plan electing to be a transferring plan or a notifying plan? (check applicable box)  Transferring  Notifying

### 2 Number of individuals reported in applicable attached schedules

(Notifying plans may omit breakdown)

(1) Account \$250 or less	(2) Account more than \$250	(3) Total
_____	_____	0

3 Amended filings only - Did the original filing contain information on anyone who is no longer considered missing (i.e., has anyone been removed from the applicable Schedule B)? (attachment required if "Yes")  Yes  No

## Part II — Additional Information for Transferring Plans

### 4 Benefit transfer date

\_\_\_\_\_

### 5 Amounts owed to PBGC for missing distributees reported in this filing

a Aggregate account balances [sum of item 5 from all Schedules B] \_\_\_\_\_

b Administrative fee [\$35 x number reported in column (2) of item 2] \$ 0.00

c Total [item 5a + item 5b] \$ 0.00

### 6 Reconciliation (amended filings only)

a Amounts previously paid in conjunction with prior Forms MP-200 for this plan \_\_\_\_\_

b Underpayment/(overpayment) [item 5c – item 6a] \_\_\_\_\_

7 Payment method  Pay.gov  Other electronic funds transfer  Paper check

8 Default beneficiary provision — Does the plan have a default beneficiary designation provision?  Yes  No

## Part III — Certification

9 Certification – The plan administrator or qualified termination administrator must sign and complete this item.

*I certify that to the best of my knowledge and belief that all the information in this filing is true, correct and complete and has been determined in accordance with PBGC's Missing Participants regulations and instructions, including the diligent search requirements of 29 CFR § 4050.204.*

Name of person signing: First name \_\_\_\_\_ Last name \_\_\_\_\_

\_\_\_\_\_ ext \_\_\_\_\_  
email Telephone

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# Individual Information - Notifying Plans

Schedule A  
(Form MP-200)  
Approved OMB 1212-0069  
Expires ~~1/31/2021~~XXXX

This Schedule A is # \_\_\_\_\_ of \_\_\_\_\_ (insert total # of Schedules A included in this filing)

[Click here to add another Sch A](#)

## Part I — Plan/Financial Institution Information

### 1 Plan information

a Plan name \_\_\_\_\_  
b Employer identification number/plan number \_\_\_ - \_\_\_ / \_\_\_ c 8-digit PBGC Case # \_\_\_\_\_

### 2 Financial institution information

a Financial institution name \_\_\_\_\_  
b Financial institution contact information  
(1) Name \_\_\_\_\_ (2) Telephone \_\_\_ - \_\_\_ - \_\_\_ (3) email \_\_\_\_\_  
c Financial institution address  
(1) Street address \_\_\_\_\_  
(2) City \_\_\_\_\_ (3) State \_\_\_\_\_ (4) Zip \_\_\_\_\_ -

## Part II — Individual Information

Complete items 3-4 for each missing individual whose DC account was transferred to a financial institution that you are reporting to PBGC. Use additional schedules as needed.

### 3 Missing distributee information

a Identifying information  
(1) Name (last, first, middle) \_\_\_\_\_ (2) Date of birth \_\_\_\_\_  
(3) Social security number \_\_\_ - \_\_\_ - \_\_\_  
b Last-known address  
(1) Street address \_\_\_\_\_  
(2) City \_\_\_\_\_ (3) State \_\_\_\_\_ (4) Zip \_\_\_\_\_ -  
c Account information  
(1) Account number \_\_\_\_\_ (2) Account balance transferred \_\_\_\_\_

**4 Amended filing code** — If this is an amended filing, enter the applicable code to indicate whether information for this missing distributee has changed or is being reported for the first time (*see instructions*). \_\_\_\_\_

### 3 Missing distributee information

a Identifying information  
(1) Name (last, first, middle) \_\_\_\_\_ (2) Date of birth \_\_\_\_\_  
(3) Social security number \_\_\_ - \_\_\_ - \_\_\_  
b Last-known address  
(1) Street address \_\_\_\_\_  
(2) City \_\_\_\_\_ (3) State \_\_\_\_\_ (4) Zip \_\_\_\_\_  
c Account information  
(1) Account number \_\_\_\_\_ (2) Amount balance transferred \_\_\_\_\_

**4 Amended filing code** — If this is an amended filing, enter the applicable code to indicate whether information for this missing distributee has changed or is being reported for the first time (*see instructions*).

DRAFT



## Individual Information - Transferring Plans

**Schedule B**  
(Form MP-200)  
Approved OMB 1212-0069  
Expires xxxxxx

DRAFT

This Schedule B is # \_\_\_\_\_ of \_\_\_\_\_ (insert total # of Schedules B included in this filing)

**Part I — Plan Information**

**1 Plan information**

a Plan name \_\_\_\_\_  
b Employer identification number/plan number \_\_\_-\_\_\_\_\_/\_\_\_ c 8-digit PBGC Case # \_\_\_\_\_

**Part II — Individual Information**

**2 Missing distributee information**

a Name (last, first, middle) \_\_\_\_\_  
b Date of birth \_\_/\_\_/\_\_\_\_ c Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_  
d Last-known address  
(1) Street address \_\_\_\_\_  
(2) City \_\_\_\_\_ (3) State \_\_\_\_\_ (4) Zip \_\_\_\_\_  
e Other name(s) ever used (if known) \_\_\_\_\_  
f Type of missing distributee  Participant  Beneficiary (if checked, see instructions re: required attachment)

**Part III — Transfer Amount**

3 Portion attributable to pre-tax contributions \_\_\_\_\_  
4 Portion attributable to post-tax contributions Contributions Investment Earnings  
a Qualified Roth transfers \_\_\_\_\_  
b Non-qualified Roth transfers \_\_\_\_\_  
c Other \_\_\_\_\_  
5 Total transfer amount \_\_\_\_\_

6 Amount of the total reported in item 5 that is attributable to non-US-source income \_\_\_\_\_

**Part IV— Miscellaneous Information**

7 **Non-qualified Roth transfer** - If the transfer amount includes a non-qualified Roth transfer, enter the date the first Roth contribution was made. Complete only if amounts are reported in 4b \_\_/\_\_/\_\_\_\_  
8 **Beneficiary Information** Complete only if "Participant" is checked in item 2f  
a Do plan records contain a valid beneficiary election form? If yes, attach a copy of the form and complete items (b)-(d) with respect to the designated beneficiary.  Yes  No  
b Name \_\_\_\_\_ c Social Security number \_\_\_\_-\_\_\_\_-\_\_\_\_  
d Relationship \_\_\_\_\_  
9 **Amended filing code** — If this is an amended filing, enter the applicable code to indicate whether information for this missing distributee has changed or is being reported for the first time (see instructions). \_\_\_\_\_