



Missing Participants Program Plan Information for Defined Contribution Plans

Form MP-200
Approved OMB 1212-0069
Expires XXXX

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

PROPOSED

4 Benefit transfer date

5 Amounts owed to PBGC for missing distributions 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 _____

email _____

Telephone _____

Signature _____

Date _____



Individual Information - Notifying Plans

Schedule A
(Form MP-200)
Approved OMB 1212-0069
Expires 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 _____

PROPOSED

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). _____



Individual Information - Transferring Plans

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

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) _____		c Social Security Number ____-____-
b Date of birth ____/____/____		
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 <input type="checkbox"/> Participant <input type="checkbox"/> Beneficiary (if checked, see instructions re: required attachment)		

PROPOSED

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 Is any portion of the missing distributee's benefit attributable to non-US-source income?			
<input type="checkbox"/> Yes <input type="checkbox"/> No (Attachment required if "Yes")			

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. <input type="checkbox"/> Yes <input type="checkbox"/> 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). _____	