



Plan Participation Information

PBGC Form 709

Approved OMB 1212-0055

Expires

Pension Benefit Guaranty Corporation.
P.O. Box 151750, Alexandria, Virginia 22315-1750

For assistance, call 1-800-400-7242

Plan Name: FX.PrismCase.CaseTitle.XF
Plan Number: FX.PrismCase.CaseldNbr.XF
Date Printed: 02/02/2021
Date of Plan Termination: FX.PrismCase.DOPT.XF

Participant Name: FX.PrismCust.FullName.XF

INSTRUCTIONS: Please complete this form for PBGC to determine your eligibility for a pension. If you have questions, call our Customer Contact Center at 1-800-400-7242. **Print clearly with dark ink.**

1. General information about you

| | | | | | | | |
|--|--|---------------|--|--------------------------|--|------------------------|--|
| Last Name | | | | First Name | | | |
| Middle Name | | | | Other Name(s) Used | | | |
| Social Security Number | | Date of Birth | | Gender | | | |
| Mailing Address | | | | Apartment / Route Number | | | |
| City | | | | State | | Zip Code | |
| Country | | | | Email (optional) | | | |
| Daytime Phone | | EXTENSION | | Evening Phone | | | |
| Name of plan participant, if different | | | | | | Social Security Number | |

2. Participant employment information - Relating to the sponsor of the plan.

| | | | | | | | |
|---------------|--|----------------------------|--|------------------------|--|--|--|
| Employer Name | | | | City and State | | | |
| Job Title | | | | Plant or Facility | | | |
| Date of Hire | | Date Employment Terminated | | Reason for Termination | | | |

CONTINUE

Plan Number: FX.PrismCase.CaseldNmbr.XF

Participant Name: FX.PrismCust.FullName.XF

Was the plan participant covered by a collective bargaining agreement (union contract) with the employer identified above? If yes, during what period:

No

Yes

From

| | | |
|--|--|--|
| | | |
|--|--|--|

 /

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

MONTH YEAR

To

| | | |
|--|--|--|
| | | |
|--|--|--|

 /

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

MONTH YEAR

Name of Local Union:

Address

Was the plan participant ever hourly and/or a salaried employee?

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Was the plan participant transferred between hourly and salaried?

If yes, specify type and date of each transfer:

Any breaks in service?

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|

If yes, specify the period(s) (from when to when):

Please attach any documentation to verify the participant's employment and/or plan participation.

3. Signature – Sign and date this document. Knowingly and willfully making false, fictitious or fraudulent statements to the Pension Benefit Guaranty Corporation is a crime punishable under Title 18, Section 1001, United States Code.

I declare under penalty of perjury that all of the information I have provided on this form is true and correct.

SIGNATURE

DATE

SIGN & DATE BEFORE SUBMITTING. THANK YOU