Distress Termination
Notice of Intent to Terminate

PBGC Form 600
Approved OMB 1212-0036
Expires 09/30/26

PART I. IDENTIFYING INFORMATION

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

PART II. GENERAL PLAN INFORMATION

4 Proposed termination date		(MM/DD/YYYY)
5 Estimated number of plan participants as of the proposed termination date		
a Active participants:		
(i) Fully vested	**5a** (i)	
(ii) Partially vested	**5a** (ii)	
(iii) Nonvested	**5a** (iii)	
(iv) Total active participants [add a(i) through a(iii)]	**5a** (iv)	
b Retirees or beneficiaries receiving benefits	**5b**	
c Separated vested participants entitled to benefits	**5c**	
d Total [add 5a(iv) through 5c]	**5d**	

6 Changes in contributing sponsor associated with plan termination. Check all that apply.		
a No Change	**6a**	
b Sale of company/subsidiary/division (not involving bankruptcy or similar proceeding)	**6b**	
c Company/subsidiary/division closed (not involving bankruptcy or similar proceeding)	**6c**	
d Merger of company	**6d**	
e Contributing sponsor acquired by another business	**6e**	
f Another business acquired by contributing sponsor	**6f**	
g Contributing sponsor reorganized (in bankruptcy or similar proceeding)	**6g**	
h Contributing sponsor liquidated (bankruptcy or similar proceeding)	**6h**	

7	Intention concerning expected pension coverage for currently employed participants covered under the terminated plan (check all that apply):		
a	No new plan	**7a**	
b	New or existing defined benefit plan	**7b**	
c	New or existing profit-sharing plan	**7c**	
d	New or existing 401(k) plan	**7d**	
e	Other new or existing plan. Specify:	**7e**	

8a	Is there more than one contributing sponsor?	☐ Yes	☐ No
b	If "Yes," is this a multiple-employer plan?	☐ Yes	☐ No
9a	Is the contributing sponsor(s) a member of a controlled group?	☐ Yes	☐ 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.		
c	For each entity listed on the attachment for item 9b, attach a statement identifying the distress test that you expect it will meet, and describe in detail why it meets the distress test that you have identified. Based on the distress test identified for each entity, attach the required information for that test. See pages ~~[illegible]~~ of the instructions for what information is required and when a response to 9c must be submitted.		

10 Has there been a change in the composition of a contributing sponsor's controlled group with the 5-year period prior to the proposed termination date?

☐ Yes ☐ No

If "Yes," attach a statement that describes the change(s).

[Once pagination of instructions is final, page numbers will be inserted.]

11 Are all eligible participant/beneficiaries, who are entitled to and have applied for benefits, receiving such monthly benefits from the plan?

☐ Yes ☐ No

If "No," attach a statement describing (a) the reason for non-payment, (b) the number of all participants/beneficiaries who are not being paid, (c) the total monthly amount not being paid to all such participants/beneficiaries, ~~and~~ (d) the last date on which benefits were paid, and (e) the date on which benefits were last paid.

12 Are plan assets expected to be sufficient to continue to pay all benefits when due during the next 180 days?

☐ Yes ☐ No

If "No," attach a statement describing the amount and nature of the plan assets, including their liquidity, the number of participants/beneficiaries owed benefits over that period, and the total monthly amount that is owed over the period.

13a	Are any participants/beneficiaries receiving benefits in excess of estimated Title IV	☐ Yes	☐ No

b If "Yes" to 13a, are benefits scheduled to be reduced to the estimated Title IV as of the proposed termination date?

☐ Yes ☐ No

If "No," attach a statement describing why no reduction is scheduled.

14 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;
- **g** Form 5500, Schedules B and SSA (last three years);
- **h** A copy of NOIT sent to affected parties other than PBGC; and
- **i** All documents required in response to 9c.
- **j** Information relating to benefit limitations under Code §436

15a Name and address of contact for access to plan records (address should include room or suite no.)	**15b** Telephone number
	15c Type of Record

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 | Printed name and title of Plan Administrator

Distress Termination Designation of Representative

PBGC Schedule REP-D

(PBGC Form 600)
Approved OMB 1212-0036
Expires 09/30/20

PART I. IDENTIFYING INFORMATION

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

PART II. DESIGNATION OF REPRESENTATIVE(S)

3 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:

4a Representative's name and address (address should include room or suite no.)	**4b** Telephone number **4c** E-mail address (optional)
4d Representative's name and address (address should include room or suite no.)	**4e** Telephone number **4f** E-mail address (optional)

5 Matters excluded from authority of representative(s). 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)

6a Have you filed any prior designation(s) of representative(s) for **this** termination?	☐ Yes ☐ No
6b 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.)	☐ Yes ☐ No

PART IV. SIGNATURE OF PLAN ADMINISTRATOR

Note: 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 does not designate a plan administrator or it designates the plan sponsor or contributing sponsor as the plan administrator, this form must be signed by an officer of the plan sponsor or contributing sponsor who has the authority to sign on behalf of that entity.*

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	Printed name and title
Signature	Date	Printed name and title

Distress Termination Notice
Single-Employer Plan Termination

PBGC Form 601

Approved OMB 1212-0036
Expires 09/30/2038

PART I. IDENTIFYING INFORMATION

1a Plan Name	1b 9-digit employer identification number
1b Contributing Sponsor's name and address (address should include room or suite no.)	1c 3-digit plan number (PN)
2 PBGC Case Number (8 digit)	

PART II. SPECIFIC PLAN INFORMATION

3a	Proposed termination date	(MM/DD/YYYY)
3b	Proposed termination date stated in notice of intent to terminate (if different from 3a)	(MM/DD/YYYY)
4a	Earliest date notices of intent to terminate issued to affected parties (other than PBGC)	(MM/DD/YYYY)
4b	Latest date notices of intent to terminate issued to affected parties (other than PBGC)	(MM/DD/YYYY)

5 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)? ☐ Yes ☐ No

If "Yes," attach a statement listing the name, address, and employer identification number of each contributing sponsor and each controlled group member, and identify the distress test met by each. If the distress test for any one of the contributing sponsors or members of their controlled group differs from that identified in response to item 9c on the Form 600, the information and documents required for the newly identified distress test must be attached.

6 Has a formal challenge to the termination been initiated under an existing collective bargaining agreement? ☐ Yes ☐ No ☐ N/A

If "Yes," attach a copy of the formal challenge and a statement describing the challenge.

7 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? ☐ Yes ☐ No ☐ N/A

If "No," attach a statement describing why no reduction has occurred, or is not applicable.

8 Has the plan ever required employee contributions? ☐ Yes ☐ No

9 Have you filed or will you file with the Internal Revenue Service an application for a determination letter on the termination of this plan? ☐ Yes ☐ No

If "Yes," enter the filing date: (MM/DD/YYYY) _____

10 Are there outstanding employer contributions owed to the plan that have not been paid to the plan for which minimum funding waivers have not been granted and for which waiver requests are not pending. ☐ Yes ☐ No

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 09/30/20[illegible]

PART I. IDENTIFYING INFORMATION

1a Plan Name	**1b** 9-digit employer identification number (EIN)
	1c 3-digit plan number (PN)

PART II. SUFFICIENCY LEVEL AS OF PROPOSED TERMINATION DATE

2 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?	☐ Yes ☐ No
b equal to or greater than the value of guaranteed benefits, but less than the value of benefit liabilities?	☐ Yes ☐ No
c equal to or greater than the value of benefit liabilities?	☐ Yes ☐ No
If you checked "Yes" in 2a, complete the rest of Part II and complete Part IV. Do not complete Part III. If you checked "No" in 2a, complete the rest of Part II, Part III, and Part IV.	
3 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 3b	$
d Estimated value of total plan assets (sum of a and c)	$
4 Estimated value of Title IV benefits as of the proposed termination date	$
5 Estimated present value of all benefit liabilities as of the proposed termination date	$

PART III. SUFFICIENCY LEVEL AS OF PROPOSED DISTRIBUTION DATE

6 Proposed distribution date	(MM/DD/YYYY)
7 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?	☐ Yes ☐ No
b all benefit liabilities?	☐ Yes ☐ No

PART IV. ENROLLED ACTUARY CERTIFICATION

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):

☐ Insufficient for guaranteed benefits ☐ Sufficient for guaranteed benefits but not for benefit liabilities ☐ Sufficient for benefit liabilities

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's 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)

Post-Distribution Certification for Distress Termination

PBGC Form 602

Approved OMB 1212-0036
Expires 09/30/20[illegible]

PART I. IDENTIFYING INFORMATION

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

PART II. DISTRIBUTION INFORMATION

3a Last distribution date in satisfaction of guaranteed or plan benefits	(MM/DD/YYYY)
3b Date of receipt of IRS determination letter	(MM/DD/YYYY)
4 Latest date notices of benefit distribution issued to participants or beneficiaries	(MM/DD/YYYY)
5 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.)	☐ Yes ☐ No
6 Were you able to locate all participants and beneficiaries? If "No," see instructions.	☐ Yes ☐ No

7 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?

☐ Yes, enter latest date the annuity contract, certificate or written notice was provided to participants and beneficiaries_____(MM/DD/YYYY)

☐ No, see instructions

☐ N/A, see instructions

8a Complete office address(es) of insurer(s), if any, from whom annuity contracts have been purchased (address should include room or suite no.)	**8b** Annuity Contract Number(s)
9a Name and address of contact for location of plan records (address should include room or suite no.)	**9b** Telephone number

10 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)		
(1) Consensual		$
(2) Nonconsensual		$
c Designated benefits paid to PBGC for Missing Participants		$
d No Distribution		
e TOTAL (See instructions)		$

PART III. PLAN ADMINISTRATOR CERTIFICATION

I, the Plan Administrator, certify that to the best of my knowledge and belief (1) benefits payable with respect to participants have been calculated and valued correctly in accordance with applicable provisions of ERISA and the regulations thereunder; (2) all (check one) ☐ guaranteed benefits OR ☐ benefit liabilities under the plan have been satisfied, and (3) the information contained in this filing is true, correct, and complete. I further certify that 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 address (address should include room or suite no.)	Telephone number Name of Plan Administrator Title of Plan Administrator
Plan Administrator's signature Date	