

Revised 12/19/2013



**Standard Termination Notice
Single-Employer Plan Termination**

PBGC Form 500

Approved OMB 1212-0036
Expires 12/31/2013

PART I. IDENTIFYING INFORMATION	
1a Plan Name	1b 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 for this contributing sponsor/plan in previous filings with the PBGC, also show the number(s) previously reported.	2f 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	
4a Have you filed, or will you file, with the Internal Revenue Service for a determination letter on the termination of this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	4b If "Yes" to 4a, enter the filing date: (MM/DD/YYYY)
5a Is this a multiple-employer plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	5b If "Yes" to 5a, attach a list of the names and employer identification numbers of all contributing sponsors

6 Reason for plan termination. If more than one reason for the termination (considering (1) - (12) and c.), see instructions.	a Plan related	
	(1) Plan administration too costly or complicated	6a (1)
	(2) Plan benefits too costly	6a (2)
	(3) Restructuring of retirement program (e.g. adoption of new plan, decision that defined benefit plan no longer meets employer objectives)	6a (3)
	(4) Retirement/illness/death of owner(s)	6a (4)
	b Business related	
	(5) Adverse business conditions	6b (5)
	(6) Sale of company/subsidiary/division (not involving bankruptcy or similar proceeding)	6b (6)
	(7) Company/subsidiary/division closed (not involving bankruptcy or similar proceeding)	6b (7)
	(8) Merger of company	6b (8)
	(9) Contributing sponsor acquired by another business	6b (9)
	(10) Another business acquired by contributing sponsor	6b (10)
	(11) Contributing sponsor reorganized (in bankruptcy or similar proceeding)	6b (11)
(12) Contributing sponsor liquidated (in bankruptcy or similar proceeding)	6b (12)	
c Other (specify) _____	6c	

7 Changes in contributing sponsor associated with plan termination (check all that apply).	a No change	7a	<input type="checkbox"/>
	b Sale of company/subsidiary/division (not involving bankruptcy or similar proceeding)	7b	<input type="checkbox"/>
	c Company/subsidiary/division closed (not involving bankruptcy or similar proceeding)	7c	<input type="checkbox"/>
	d Merger of company	7d	<input type="checkbox"/>
	e Contributing sponsor acquired by another business	7e	<input type="checkbox"/>
	f Another business acquired by contributing sponsor	7f	<input type="checkbox"/>
	g Contributing sponsor reorganized (in bankruptcy or similar proceeding)	7g	<input type="checkbox"/>
	h Contributing sponsor liquidated (in bankruptcy or similar proceeding)	7h	<input type="checkbox"/>

8 Number of plan participants and beneficiaries as of proposed termination date:		
a Active participants		8a
b Retirees or beneficiaries receiving benefits		8b
c Separated vested participants entitled to benefits	<i>d. Separated non-vested participants.</i>	8c
<i>e</i> Total		8d <i>6</i>
9 Estimated percent of currently employed participants that are covered under the terminated plan that you expect to be covered under:		
a No plan		9a %
b New or existing traditional defined benefit plan		9b %
c New or existing hybrid defined benefit plan, other than cash balance plan		9c %
d New or existing cash balance plan		9d %
e New or existing profit sharing plan		9e %
f New or existing 401(k) plan		9f %
g New or existing simplified employee plan		9g %
h Other new or existing defined contribution plan (specify) _____		9h %
10 If the percent entered for item 9b, 9c or 9d is greater than zero, will the types of benefits under the new or existing defined benefit plan be substantially the same as under the terminating plan for all affected participants (currently employed participants that you expect will be covered under the new or existing defined benefit plan.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
11a Proposed termination date	(MM/DD/YYYY)	
11b Proposed termination date stated in notice of intent to terminate (if different from 11a)	(MM/DD/YYYY)	
12a Earliest date notices of intent to terminate issued to affected parties	(MM/DD/YYYY)	
12b Latest date notices of intent to terminate issued to affected parties	(MM/DD/YYYY)	
13 Latest date notices of plan benefits issued to participants or beneficiaries	(MM/DD/YYYY)	
14a 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	
14b If "Yes" to 14a, attach a copy of the formal challenge and a statement describing the challenge.		
15 Have all PBGC premiums been paid to date?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

PART III RESIDUAL PLAN ASSETS

16a Will residual assets be returned to the employer as a result of this termination?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
16b If "No" or "N/A" to 16a, do not complete the rest of Part III; go to Part IV. If "Yes," enter the estimated amount:	\$ _____	
17a Is there a plan provision permitting a reversion of residual assets to the employer?	<input type="checkbox"/> Yes, go to 17b <input type="checkbox"/> No, go to 18a	
17b If "Yes" to 17a, was the provision adopted prior to 12/18/1988?	<input type="checkbox"/> Yes, go to 18a <input type="checkbox"/> No, go to 17c	
17c If "No" to 17b, enter: (1) Adoption date: (2) Effective date of plan:	(MM/DD/YYYY) (MM/DD/YYYY)	
18a Has the plan been involved in a spin-off/termination transaction?	<input type="checkbox"/> Yes, go to 18b <input type="checkbox"/> No, go to Part IV	
18b If "Yes," to 18a, have the requirements of the Guidelines been satisfied?	<input type="checkbox"/> Yes, go to 18c <input type="checkbox"/> No, go to 18d <input type="checkbox"/> N/A, go to 18d	
18c If "Yes" to 18b, enter the dates for (1) and (2) and go to Part IV: (1) latest date a description of the transactions(s) was issued to participants in the ongoing plan. (2) latest date notices of plan benefits were issued to participants in the ongoing plan.	(MM/DD/YYYY) (MM/DD/YYYY)	
18d If you checked "No" or "N/A" in 18b, attach a statement that describes the transaction(s) and explains why the Guidelines were not, or need not have been, followed.		

PART IV 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



**Standard Termination
Certification of Sufficiency**

PBGC Schedule EA-S

(PBGC Form 500)
Approved OMB 1212-0036
Expires 12/31/2013

PART I IDENTIFYING INFORMATION

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

PART II CODE SECTION 412(i) PLANS

2 Is this plan a Code section 412(i) plan?

No: the Enrolled Actuary must complete Parts III and IV. Item 3 and Part V should not be completed.

Yes: Item 3 and Part III must be completed. Depending upon who completes Part III, either Part IV or Part V must be completed and signed by the Plan Administrator or Enrolled Actuary as appropriate.

3a Enter name (full official name of record) and address of the insurer (Address should include room or suite no.)	3b Telephone Number
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PART III PLAN SUFFICIENCY

4 Proposed distribution date	(MM/DD/YYYY)
5 Is the value of plan assets projected to be sufficient as of the proposed distribution date to provide all plan benefits? If "No," the plan cannot terminate in a standard termination.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6 Estimated fair market value of plan assets as of the proposed distribution date	\$
7 Estimated present value of plan benefits as of the proposed distribution date	\$
8 Estimated total amount of residual assets	\$
9 Estimated amount of residual assets to be distributed to the employer	\$
10 Estimated amount of residual assets to be distributed to participants and beneficiaries	\$
11 Has the plan ever required employee contributions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12 If the amount in item 9 is \$1 million or more and if any benefits are to be distributed other than through the purchase of annuity contracts, attach a statement showing interest rate/structure used to value the benefits.	

PART IV ENROLLED ACTUARY CERTIFICATION

I, the Enrolled Actuary, certify that: (1) I have reviewed all plan documents and plan and participant data, and applied all relevant provisions of ERISA and the Internal Revenue Code and regulations promulgated thereunder; (2) to the best of my knowledge and belief, this plan's assets equal or exceed the value of its plan benefits as of the proposed distribution date; and (3) to the best of my knowledge and belief, the information contained in this schedule 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.

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
	E-mail address (optional)
Enrolled Actuary's signature	Date

PART V PLAN ADMINISTRATOR CERTIFICATION FOR CODE SECTION 412(i) PLANS

I, the Plan Administrator, certify that, to the best of my knowledge and belief: (1) this plan complies with section 412(i) of the Internal Revenue Code and regulations promulgated thereunder; (2) I have reviewed all plan documents and plan and participant data, and applied all relevant provisions of ERISA and the Code and regulations promulgated thereunder; (3) this plan's assets equal or exceed the value of its plan benefits as of the proposed distribution date; and (4) the information contained in this schedule 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
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**Standard Termination
Designation of Representative**

PBGC Schedule REP-S

(PBGC Form 500)
Approved OMB 1212-0038
Expires 12/31/2013

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 <u>this</u> termination?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.)	<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 does not designate a plan administrator or it designates the plan sponsor or the 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



Post-Distribution Certification for Standard Termination

(or deemed distribution date for plans with designated benefits for Missing Participants that will be paid to PBGC)

PBGC Form 501

Approved OMB 1212-0038
Expires 12/31/2013

PART I IDENTIFYING INFORMATION

Check here if you previously filed a Form 501 for this plan. If checked, provide dates of filing(s): _____

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

PART II DISTRIBUTION INFORMATION

3a Last distribution date in satisfaction of plan benefits	(MM/DD/YYYY)
3b Date of receipt of IRS determination letter	(MM/DD/YYYY)
4 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 22 of instructions.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5 Were you able to locate all participants and beneficiaries? If "No," see instructions.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6a 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
6b If "Yes" to 6a, enter the latest date the annuity contract, certificate, or written notice was provided to each participant and beneficiary receiving benefits: If "No" or "N/A", see instructions	(MM/DD/YYYY)
7a Complete name of record of insurer(s) from whom annuity contracts, if any, have been purchased (Address should include room or suite no.)	7b Annuity Contract Number(s)
8a Name and address of contact for location of plan records (Address should include room or suite no.)	8b Telephone number

9 Summary of distribution of plan benefits		
Type of Benefit	(1) # of Participants or Beneficiaries	(2) 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 that (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 plan benefits (through priority category 6 under ERISA Section 4044 and 29 CFR Part 4044) under the plan have been satisfied; (3) plan assets in excess of those needed to satisfy all plan benefits (through priority category 6 under ERISA Section 4044 and 29 CFR Part 4044) have been or will be distributed in accordance with applicable provisions of ERISA and the regulations thereunder; and (4) 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 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.

Plan Administrator's company name and address (Address should include room or suite no.)	Telephone number
<i>(2) Other amounts due to PBGC for Missing Participants</i>	E-mail address (optional)

Plan Administrator's signature _____ Date _____ Printed name and title of Plan Administrator _____