



**Missing Participants Program
Plan Information for PBGC-Insured Multiemployer
Defined Benefit Plans**

Form MP-400
Approved OMB 1212-####
Expires xx/xx/xxxx

Amended Filing-Type 1 Amended Filing-Type 2

Aug 1 draft

Part I — Identifying Information	
1 Plan information	
a Plan name _____	
b Employer identification number/plan number ____ - ____ - ____ / ____	
c Plan contact	
(1) Name _____	(2) Telephone _____
(3) email _____	
(4) Street address _____	
(5) City _____	(6) State _____
(7) Zip _____	

Part II — Amounts Transferred to PBGC	
2 Number of individuals for whom benefits are being transferred to PBGC	
a Number with benefit transfer amounts of \$250 or less	_____
b Number with benefit transfer amounts in excess of \$250	_____
c Total	_____
3 Benefit transfer date	__/__/____
4 Amounts owed to PBGC for missing distributees reported in this filing	
a Aggregate benefit-related transfer amount [sum of item 5 from all Schedules B]	_____
b Administrative fee [\$35 x item 2b]	_____
c Total [item 4a + item 4b]	_____
d Amounts previously paid (in conjunction with prior Forms MP-400 for this plan)	_____
e Net amount due [item 4c – item 4d]	_____

Part III — Diligent Search Information
5 Summarize the steps taken to satisfy the diligent search requirements and report the name of any commercial locator service used to assist with the search: _____ _____ _____

Part IV — Plan Sponsor Certification	
6 Certification of plan sponsor – The plan sponsor must sign and complete this item.	
I certify that to the best of my knowledge and belief that: (1) 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, and (2) I have met the diligent search requirements of 29 CFR § 4050.104.	
Name of person signing: First name _____ Last name _____	
_____	_____ ext _____
E-mail address _____	Telephone _____
_____	____/____/____
Signature	Date



Individual Information - Transfer to PBGC

Schedule B
(Form MP-400)
Approved OMB 1212-####
Expires xx/xx/xxxx

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

Part I — Identifying Information

1 Plan sponsor information

- a Plan name _____
- b Employer identification number/plan number ____-____-____/____-____

2 Missing distributee identifying information

- a Missing distributee's name (last, first, middle) _____
- b Social Security Number ____-____-____ c 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 Participant Beneficiary (See instructions re: required attachment)
- g Has the missing distributee received any benefit payments from this plan? Yes No
(If "yes", see instructions re: required attachment)
- h If any portion of the benefit due is attributable to mandatory employee contributions, enter the accumulated value of such contributions as of the Benefit Transfer Date _____
- i 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). _____

Part II — Benefit-Related Transfer Amount

- 3 Benefit transfer amount _____
- 4 Plan make-up amount, if applicable _____
- 5 Total _____

Part III — Missing Participant Benefit Information

Complete this item only if "Participant" was checked in item 2g and total amount in item 5 exceeds \$5,000

- 6 Lump sum eligibility – Is this participant eligible to elect a lump sum? Yes No
- 7 Annuity information – Monthly straight life annuity to which participant is entitled assuming benefit commencement begins at each of the ages below. See instructions for information about which entries may be left blank.

55 _____	58 _____	61 _____	64 _____	67 _____	70 _____
56 _____	59 _____	62 _____	65 _____	68 _____	71 _____
57 _____	60 _____	63 _____	66 _____	69 _____	RBD _____