



# Missing Participants Program Plan Information for Single-Employer DB Plans Insured by PBGC

**Form MP-100**  
Approved OMB 1212-####  
Expires xx/xx/xxxx

Amended Filing

*Pending OMB approval*

Part I — General Information			
<b>1 Plan information</b>			
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 _____	
<b>2 Number of missing distributees</b>			
	(1)	(2)	(3)
	Benefit transfer amounts more than \$250	Benefit transfer amounts \$250 or less	Total
a Annuity purchases	_____	_____	_____
b Benefits being transferred to PBGC	_____	_____	_____
c Total	_____	_____	_____
<b>3 Benefit determination date (BDD)</b> _____/____/____			
<b>4 Commercial locator service(s) used</b> (if any) _____			
<b>5 Amended filings only</b> - Did the original filing contain information on anyone who is not reported in this amended filing (i.e., has anyone been removed from Schedule A or B)? (attachment required if "Yes") <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			

Part II — Amount due to PBGC	
<b>6 Amounts owed to PBGC for missing distributees reported in this filing</b>	
a Aggregate benefit transfer amount as of BDD [sum of item 3 from all Schedules B]	_____
b Administrative fee [\$35 x item 2b from column (1) or sum of item 4 from all Schedules B]	_____
c Aggregate late payment charge [sum of item 5b from all Schedules B]	_____
d Total [item 6a + item 6b + item 6c]	_____
<b>7 Reconciliation (amended filings only)</b>	
a Amounts previously paid in conjunction with prior Forms MP-100 for this plan	_____
b Underpayment/(overpayment) [item 6d – item 7a]	_____
<b>8 Payment method</b> <input type="checkbox"/> Pay.gov <input type="checkbox"/> Other electronic funds transfer <input type="checkbox"/> Paper check	

Part III — Plan Administrator Certification	
<b>9 Certification of plan administrator</b> – The plan administrator must sign and complete this item.	
<i>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 § 4050.104.</i>	
Name of person signing: First name _____ Last name _____	
_____	_____ ext _____
email	Telephone
_____	_____
Signature	Date



# Individual Information - Annuity Purchases

Schedule A  
(Form MP-100)  
Approved OMB 1212-####  
Expires xx/xx/xxxx

This Schedule A is # \_\_\_\_\_ of \_\_\_\_\_ (insert total # of Schedules A included in this filing)

## Part I — Plan/Insurance Company Information

### 1 Plan information

a Plan name \_\_\_\_\_  
b Employer identification number/plan number \_\_ - \_\_\_\_ / \_\_\_\_ c 8-digit PBGC Case # \_\_\_\_\_

### 2 Insurance company information

a Insurance company name \_\_\_\_\_ b Policy number \_\_\_\_\_  
c Insurance company contact information  
(1) Name \_\_\_\_\_ (2) Telephone \_\_\_\_ - \_\_\_\_ - \_\_\_\_ (3) email \_\_\_\_\_  
d Insurance company address  
(1) Street address \_\_\_\_\_  
(2) City \_\_\_\_\_ (3) State \_\_\_\_ (4) Zip \_\_\_\_\_

## Part II — Individuals for whom Annuities were Purchased

Complete items 3-4 for each missing individual for whom an annuity was purchased. If more than two individuals need to be reported, 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 \_\_\_\_ - \_\_\_\_ - \_\_\_\_ (4) Certificate # \_\_\_\_\_  
b Last-known address  
(1) Street address \_\_\_\_\_  
(2) City \_\_\_\_\_ (3) State \_\_\_\_ (4) Zip \_\_\_\_\_  
c Accrued benefit (enter amount and check applicable box) \_\_\_\_\_  Monthly benefit  Current value

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 \_\_\_\_ - \_\_\_\_ - \_\_\_\_ (4) Certificate # \_\_\_\_\_  
b Last-known address  
(1) Street address \_\_\_\_\_  
(2) City \_\_\_\_\_ (3) State \_\_\_\_ (4) Zip \_\_\_\_\_  
c Accrued benefit (enter amount and check applicable box) \_\_\_\_\_  Monthly benefit  Current value

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 - Transfer to PBGC

**Schedule B**  
(Form MP-100)  
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 information**

- a Plan name \_\_\_\_\_
- b Employer identification number/plan number \_\_\_\_-\_\_\_\_\_/\_\_\_\_\_      c 8-digit PBGC Case # \_\_\_\_\_
- d Benefit determination date (BDD) per Form MP-100 \_\_/\_\_/\_\_\_\_

**2 Missing distributee identifying information**

- a Missing distributee's name (last, first, middle) \_\_\_\_\_
- b Date of birth \_\_/\_\_/\_\_\_\_\_      c Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_
- 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 missing distributee received any benefit payments from this plan? *(Attachment required if "Yes")*       Yes  No
- h Is any portion of the benefit attributable to employee contributions? *( Attachment required if "Yes")*       Yes  No
- 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 – Amount Owed to PBGC

- 3 Benefit transfer amount as of benefit determination date (BDD)** \_\_\_\_\_
- 4 Administrative fee** *(if item 3 > \$250, enter \$35, otherwise enter \$0)* \_\_\_\_\_
- 5 Late payment charge**
  - a Late payment *(Portion of item 3 transferred, or to be transferred, more than 90 days after BDD)* \_\_\_\_\_
  - b Interest owed on late payment *(If item 5a is \$0, enter \$0; otherwise, see instructions)* \_\_\_\_\_

### Part III — Missing Participant Benefit Information

*Complete this part only if "Participant" was checked in item 2f, "no" was checked in item 2g, and amount in item 3 exceeds \$5,000*

- 6 Lump sum eligibility** – Was participant eligible to elect a lump sum?       Yes  No
- 7 Normal retirement date\***      \_\_/\_\_/\_\_\_\_
- 8 Annuity information**
  - a Monthly straight life annuity payable starting at Benefit Determination Date  
*Complete this item only if the participant is over age 55 and eligible to commence benefits at the BDD and has not yet reached Normal Retirement Age.* \_\_\_\_\_
  - b Monthly straight life annuity payable that the participant is entitled to assuming payments commence at each applicable age below. Enter N/A for ages/dates: (a) after the participant's NRD\*; (b) before the participant would have been eligible to commence benefits had the plan not terminated; or (c) before BDD.
 

55 _____	58 _____	61 _____	64 _____
56 _____	59 _____	62 _____	65 _____
57 _____	60 _____	63 _____	NRD* _____

\*Or if later, the date benefit accruals ceased.