



Missing Participants Program Plan Information for Multiemployer DB Plans Insured by PBGC

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

Amended Filing

Pending OMB approval

Part I — General Information			
1 Plan information			
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 _____	
2 Number of missing distributees			
	(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	_____	_____	_____
3 Benefit determination date (BDD) _____/____/____			
4 Commercial locator service(s) used (if any) _____			
5 Amended filings only - 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") <input type="checkbox"/> Yes <input type="checkbox"/> No			

Part II — Amount due to PBGC	
6 Amounts owed to PBGC for missing distributees reported in this filing	
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]	_____
7 Reconciliation (amended filings only)	
a Amounts previously paid in conjunction with prior Forms MP-400 for this plan	_____
b Underpayment/(overpayment) [item 6d – item 7a]	_____
8 Payment method <input type="checkbox"/> Pay.gov <input type="checkbox"/> Other electronic funds transfer <input type="checkbox"/> Paper check	

Part III — Plan Sponsor Certification	
9 Certification of plan sponsor – The plan sponsor must sign and complete this item.	
<p><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 § 4050.404.</i></p>	
Name of person signing: First name _____ Last name _____	
_____ email _____	_____ Telephone _____
_____ Signature _____	_____ Date _____



Individual Information - Annuity Purchases

Schedule A
(Form MP-400)
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 Number _____
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-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 information

- a Plan name _____
- b Employer identification number/plan number ____-_____/_____ c 8-digit PBGC Case # _____
- d Benefit determination date (BDD) per Form MP-400 __/__/____

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.