PBGC Form 712

Uniformed Services Information Form

Pension Benefit Guaranty Corporation.
P.O. Box 151750, Alexandria, Virginia 22315-1750

For assistance, call 1-800-400-7242

Plan Name: FX.PrismCase.CaseTitle.XF
Plan Number: FX.PrismCase.CaseIdNmbr.XF
Participant Name: FX.PrismCust.FullName.XF
Date Printed: 04/07/2021
Date of Plan Termination: FX.PrismCase.DOPT.XF

INSTRUCTIONS: Please complete this form for PBGC to determine your eligibility for additional pension service under the Uniformed Services Employment and Reemployment Rights Act (USERRA). This form applies **only** for the period of uniformed service that includes your plan's termination date. Note those items marked "Proof Required" **and** enclose a copy of the appropriate document if you have not already sent it to us. Acceptable documents for each item requiring proof are described in the letter accompanying this form. If you have questions, call our Customer Contact Center at 1-800-400-7242. **Print clearly with blue or black ink.**

1. General information about you

Last Name	First Name
Middle Name	Other Last Name(s) Used
Social Security Number	Date of Birth Month Day Year	Gender
Mailing Address	Apartment / Route Number
City	State	Zip Code
Country	Email (optional)
Daytime Phone	Extension	Evening Phone

2. Information about your service in the Uniformed Services ("uniformed service") (Proof Required)

A. Your plan terminated on FX.PrismCase.DOPT.XF. If, on the date your plan terminated, you were —

- In uniformed service
- Recently returned from uniformed service, or
- Recovering from injuries or illness incurred during your uniformed service

Check here ☐ and go to 2.B

Note: If none of the above applied to you on the date your plan terminated, you do not qualify for this benefit and you do not need to complete the rest of this form.

B. Your **last period of uniformed service** that began before the date your plan terminated.

Beginning date		Ending date		
Month /	Year	Monthh /		

CONTINUE ON BACK

Approved OMB 1212-0055
Expires xx/xx/xx

2. Information about your service in the Uniformed Services ("uniformed service") – Cont'd from page 1

C. If you were hospitalized or recovering from an illness or injury incurred during your uniformed service, on or before the ending date reported in 2.B. – Check here ☐ and provide date of recovery, if applicable.

☐☐ / ☐☐☐☐

3. Information about your discharge or separation from uniformed service (Proof Required)

If you were discharged or separated from uniformed service under honorable conditions, or if you remained in the reserves or federal national guard after your period of uniformed service in 2.B., check here ☐

Note: If this box is not checked, you do not qualify for this benefit and you do not need to complete the rest of this form.

4. Information about your employment with the employer who sponsored your pension plan (Proof Required)

A. Date you last worked for the employer who sponsored your pension plan before the beginning date reported in 2.B.

Date: ☐☐ / ☐☐ / ☐☐☐☐

B. Date you applied for re-employment (if applicable) after the ending date in 2.B.

Date: ☐☐ / ☐☐ / ☐☐☐☐

C. The first day you worked for the employer after the ending date in 2.B.

Date: ☐☐ / ☐☐ / ☐☐☐☐

5. Signature – Sign and date this document. Knowingly and willfully making false, fictitious or fraudulent statements to the Pension Benefit Guaranty Corporation is a crime punishable under Title 18, Section 1001, United States Code.

I declare under penalty of perjury that all of the information I have provided on this form is true and correct.

SIGNATURE DATE

SIGN & DATE BEFORE SUBMITTING. THANK YOU