



Missing Participants Program Plan Information for Small Professional Service DB Plans

Form MP-300
Approved OMB 1212-0069
Expires xx/xx/xxxx

Amended Filing

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 _____ (8) email _____

e Is plan electing to be a transferring plan or a notifying plan? (check applicable box) Transferring Notifying

	(1)	(2)	(3)
2 Number of individuals reported in applicable attached schedules <i>(Notifying plans may omit breakdown)</i>	Benefit transfer amounts \$250 or less	Benefit transfer amounts more than \$250	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 no longer considered missing (i.e., has anyone been removed from the applicable Schedule B)? (attachment required if "Yes") Yes No

Part II — Additional Information for Transferring Plans

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 number reported in column (2) of item 2] _____

c Aggregate late payment charge [sum of item 5b from all Schedules B] _____

d Subtotal [item 6a + item 6b + item 6c] _____

7 Reconciliation (amended filings only)

a Amounts previously paid in conjunction with prior Forms MP-300 for this plan _____

b Underpayment/(overpayment) [item 6d – item 7a] _____

8 Payment method Pay.gov Other electronic funds transfer Paper check

Part III — Plan Administrator Certification

9 Certification of plan administrator – The plan administrator must sign and complete this item.

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 § 4050.304.

Name of person signing: First name _____ Last name _____

_____ ext _____
e-mail Telephone
_____ / ____ / ____
Signature Date



Individual Information – Notifying Plans

Schedule A
(Form MP-300)
Approved OMB 1212-0069
Expires xx/xx/xxxx

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

Part I – Plan/Financial Institution Information

1 Plan sponsor information

a Plan name _____
b Employer identification number/plan number __ - ____ / ____ c 8-digit PBGC Case # _____

2 Financial institution information

a Financial institution name _____
b Financial institution contact information
(1) Name _____ (2) Telephone _____ (3) email _____
c Financial institution address
(1) Street address _____
(2) City _____ (3) State _____ (4) Zip _____

Part II – Individual Information

Complete items 3-4 for each missing individual whose benefit was transferred to a financial institution that you are reporting to PBGC. 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 ____ - ____ - ____
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
d Account/certificate number (f applicable) _____

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 ____ - ____ - ____
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
d Account/certificate number (f applicable) _____

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 – Transferring Plans

Schedule B
(Form MP-300)
Approved OMB 1212-0069
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-300 ____/____/____

2 Missing distributee information – If the participant is deceased, enter information about the missing beneficiary.

- 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 missing distributee’s benefit attributable to non-U.S.-source income? (Attachment required if “Yes”) Yes No
- i Is any portion of the benefit attributable to employee contributions? (Attachment required if “Yes”) Yes No
- j Beneficiary information Complete only if “Participant” is checked in item 2f
 - (1) Does the plan have a default beneficiary designation provision? (Attachment required if “Yes”) Yes No
 - (2) Do plan records contain a valid beneficiary election form? If yes, attach a copy of the form and complete items (3)-(5) with respect to the designated beneficiary Yes No
 - (3) Name _____ (4) Social Security Number ____-____-____
 - (5) Relationship _____
- k 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 – Transfer Amount

- 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 the de minimis threshold (i.e., \$7,000 if Benefit Determination Date is 1/1/2024 or later, otherwise \$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 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.