



# Missing Participants Program Plan Information for Defined Contribution Plans

Form MP-200  
Approved OMB 1212-0069  
Expires 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 \_\_\_ - \_\_\_ - \_\_\_ ext \_\_\_\_\_ (8) email \_\_\_\_\_

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

2 Number of missing distributees reported in applicable attached schedules (Notifying plans may omit breakdown)	(1) Account \$250 or less	(2) Account more than \$250	(3) Total
_____	_____	_____	_____

3 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

4 Default beneficiary provision — Does the plan have a default beneficiary designation provision? (attachment required if "Yes")  Yes  No

5 Benefit transfer date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### 6 Amounts owed to PBGC for missing distributees reported in this filing

a Aggregate account balances [sum of item 5 from all Schedules B] \_\_\_\_\_

b Administrative fee [\$35 x number reported in column (2) of item 2] \_\_\_\_\_

c Total [item 6a + item 6b] \_\_\_\_\_

### 7 Reconciliation (amended filings only)

a Amounts previously paid in conjunction with prior Forms MP-200 for this plan \_\_\_\_\_

b Underpayment/(overpayment) [item 6c – item 7a] \_\_\_\_\_

8 Payment method  Pay.gov  Other electronic funds transfer

## Part III — Certification

9 Certification – The plan administrator (PA) or qualified termination administrator (QTA) must sign and complete this item. Check applicable box to indicate the applicable role of the person certifying this filing:  PA  QTA

*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 § 4050.204.*

Name of person signing: First name \_\_\_\_\_ Last name \_\_\_\_\_

\_\_\_\_\_ email \_\_\_\_\_ Telephone \_\_\_\_\_ ext \_\_\_\_\_

\_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_



# Individual Information – Notifying Plans

**Schedule A**  
(Form MP-200)  
Approved OMB 1212-0069  
Expires XXXX

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

## Part I – Plan/Financial Institution Information

### 1 Plan 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 DC account 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 Account information  
(1) Account number \_\_\_\_\_ (2) Account balance transferred \_\_\_\_\_

**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 Account information  
(1) Account number \_\_\_\_\_ (2) Amount balance transferred \_\_\_\_\_

**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-200)  
 Approved OMB 1212-0069  
 Expires XXXX

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

## Part I – Plan Information

**1 Plan information**

a Plan name \_\_\_\_\_

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

## Part II – Individual Information

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

a 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 *(if checked, see instructions re: required attachment)*

## Part III – Transfer Amount

**3** Portion attributable to pre-tax contributions \_\_\_\_\_

	Contributions	Investment Earnings	Total
<b>4</b> Portion attributable to post-tax contributions			
a Qualified Roth transfers	_____	_____	_____
b Non-qualified Roth transfers	_____	_____	_____
c Other <i>(Attachment required if greater than \$0)</i>	_____	_____	_____

**5** Total transfer amount \_\_\_\_\_

**6** Is any portion of the missing distributee’s benefit attributable to non-US-source income?  
 Yes     No *(Attachment required if “Yes”)*

## Part IV – Miscellaneous Information

**7 Non-qualified Roth transfer** – If the transfer amount includes a non-qualified Roth transfer, enter the date the first Roth contribution was made. *Complete only if amounts are reported in 4b.*      \_\_ / \_\_ / \_\_\_\_

**8 Beneficiary Information** – *Complete only if “Participant” is checked in item 2f*

a Do plan records contain a valid beneficiary election form? *If yes, attach a copy of the form and complete items (b)-(d) with respect to the designated beneficiary.*       Yes     No

b Name \_\_\_\_\_      c Social Security number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

d Relationship \_\_\_\_\_

**9 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)*.      \_\_\_\_\_