# Standard Termination Notice
# Single-Employer Plan Termination

**PBGC Form 500**
Approved OMB 1212-0036
Expires 11/30/2017

## PART I. IDENTIFYING INFORMATION

| | |
|---|---|
| **1a** Plan Name | **1b** Last day of plan year |
| **2a** Contributing Sponsor's name and address (Address should include room or suite no.) | **2b** Sponsor's telephone number<br>**2c** 9-digit employer identification number (EIN)<br>**2d** 3-digit plan number (PN) |
| **2e** If you used a different EIN or PN for this contributing sponsor/plan in previous filings with the PBGC, also show the number(s) previously reported | **2f** 6-digit business code |
| **3a** Plan Administrator's name and address (if same as 2a, enter "same") (Address should include room or suite no.) | **3b** Plan Administrator's telephone number<br>**3c** E-mail address (optional) |
| **3d** Name and address of person to be contacted for more information (if same as 3a, enter "same") (Address should include room or suite no.) | **3e** Telephone number<br>**3f** E-mail address (optional) |

## PART II. GENERAL PLAN INFORMATION

| | | |
|---|---|---|
| **4a** Have you filed, or will you file, with the Internal Revenue Service for a determination letter on the termination of this plan? | ☐ Yes<br>☐ No | **4b** If "Yes" to 4a, enter the filing date: (MM/DD/YYYY) |
| **5a** Is this a multiple-employer plan? | ☐ Yes<br>☐ No | **5b** If "Yes" to 5a, attach a list of the names and employer identification numbers of all contributing sponsors |

**6** Reason for plan termination. If more than one reason for the termination (considering (1) - (12) and c.), see instructions.

| | | |
|---|---|---|
| **a** Plan related | | |
| (1) | Plan administration too costly or complicated | **6a**(1) |
| (2) | Plan benefits too costly | **6a**(2) |
| (3) | Restructuring of retirement program (e.g. adoption of new plan, decision that defined benefit plan no longer meets employer objectives) | **6a**(3) |
| (4) | Retirement/illness/death of owner(s) | **6a**(4) |
| **b** Business related | | |
| (5) | Adverse business conditions | **6b**(5) |
| (6) | Sale of company/subsidiary/division (not involving bankruptcy or similar proceeding) | **6b**(6) |
| (7) | Company/subsidiary/division closed (not involving bankruptcy or similar proceeding) | **6b**(7) |
| (8) | Merger of company | **6b**(8) |
| (9) | Contributing sponsor acquired by another business | **6b**(9) |
| (10) | Another business acquired by contributing sponsor | **6b**(10) |
| (11) | Contributing sponsor reorganized (in bankruptcy or similar proceeding) | **6b**(11) |
| (12) | Contributing sponsor liquidated (in bankruptcy or similar proceeding) | **6b**(12) |
| **c** Other (specify) _____ | | **6c** |

**7** Changes in contributing sponsor associated with plan termination (check all that apply)

| | | |
|---|---|---|
| **a** | No change | **7a** ☐ |
| **b** | Sale of company/subsidiary/division (not involving bankruptcy or similar proceeding) | **7b** ☐ |
| **c** | Company/subsidiary/division closed (not involving bankruptcy or similar proceeding) | **7c** ☐ |
| **d** | Merger of company | **7d** ☐ |
| **e** | Contributing sponsor acquired by another business | **7e** ☐ |
| **f** | Another business acquired by contributing sponsor | **7f** ☐ |
| **g** | Contributing sponsor reorganized (in bankruptcy or similar proceeding) | **7g** ☐ |
| **h** | Contributing sponsor liquidated (in bankruptcy or similar proceeding) | **7h** ☐ |

| | | | |
|---|---|---|---|
| **8** | Number of plan participants and beneficiaries as of proposed termination date: | | |
| **a** | Active participants | **8a** | |
| **b** | Retirees or beneficiaries receiving benefits | **8b** | |
| **c** | Separated vested participants entitled to benefits | **8c** | |
| **d** | Separated non-vested participants | **8d** | |
| **e** | Total | **8e** | |
| **9** | Estimated percent of currently employed participants that are covered under the terminated plan that you expect to be covered under: | | |
| **a** | No plan | **9a** | % |
| **b** | New or existing traditional defined benefit plan | **9b** | % |
| **c** | New or existing hybrid defined benefit plan, other than cash balance plan | **9c** | % |
| **d** | New or existing cash balance plan | **9d** | % |
| **e** | New or existing profit sharing plan | **9e** | % |
| **f** | New or existing 401(k) plan | **9f** | % |
| **g** | New or existing simplified employee plan | **9g** | % |
| **h** | Other new or existing defined contribution plan (specify) | **9h** | % |
| **10** | If the percent entered for item 9b, 9c or 9d is greater than zero, will the types of benefits under the new or existing defined benefit plan be substantially the same as under the terminating plan for all affected participants (currently employed participants that you expect will be covered under the new or existing defined benefit plan.) | ☐ Yes ☐ No | |

| | | | |
|---|---|---|---|
| **11a** | Proposed termination date | (MM/DD/YYYY) | |
| **11b** | Proposed termination date stated in notice of intent to terminate (if different from 11a) Attach copy of notice of intent to terminate. | (MM/DD/YYYY) | |
| **12a** | Earliest date notices of intent to terminate issued to affected parties | (MM/DD/YYYY) | |
| **12b** | Latest date notices of intent to terminate issued to affected parties | (MM/DD/YYYY) | |
| **13** | Latest date notices of plan benefits issued to participants or beneficiaries Attach copies of sample notices of plan benefits; see instructions. | (MM/DD/YYYY) | |
| **14a** | Has a formal challenge to the termination been initiated under an existing collective bar - gaining agreement? | ☐ Yes | ☐ No ☐ N/A |
| **14b** | If "Yes" to 14a, attach a copy of the formal challenge and a statement describing the challenge. | | |
| **15** | Have all PBGC premiums been paid to date? | ☐ Yes | ☐ No |

## PART III. RESIDUAL PLAN ASSETS

| | | | |
|---|---|---|---|
| **16a** | Will residual assets be returned to the employer as a result of this termination? | ☐ Yes | ☐ No ☐ N/A |
| **16b** | If "No" or "N/A" to 16a, do not complete the rest of Part III; go to Part IV. If "Yes," enter the estimated amount: | $_____ | |
| **17a** | Is there a plan provision permitting a reversion of residual assets to the employer | ☐ Yes, go to 17b | ☐ No, go to 18a |
| **17b** | If "Yes" to 17a, was the provision adopted prior to 12/18/1988? | ☐ Yes, go to 18a | ☐ No, go to 17c |
| **17c** | If "No" to 17b, enter: | | |
| | (1) Adoption date: | (MM/DD/YYYY) | |
| | (2) Effective date of plan: | (MM/DD/YYYY) | |
| **18a** | Has the plan been involved in a spin-off/termination transaction? | ☐ Yes, go to 18b | ☐ No, go to Part IV |
| **18b** | If "Yes" to 18a, have the requirements of the Guidelines been satisfied? | ☐ Yes, go to 18c | ☐ No, go to 18d ☐ N/A, go to 18d |
| **18c** | If "Yes" to 18b, enter the dates for (1) and (2) and go to Part IV: | | |
| | (1) latest date a description of the transactions(s) was issued to participants in the ongoing plan. | (MM/DD/YYYY) | |
| | (2) latest date notices of plan benefits were issued to participants in the ongoing plan. | (MM/DD/YYYY) | |

**18d** If you checked "No" or "N/A" in 18b, attach a statement that describes the transaction(s) and explains why the Guidelines were not, or need not have been, followed.

## PART IV. PLAN ADMINISTRATOR CERTIFICATION

I, the Plan Administrator, certify that, to the best of my knowledge and belief: (1) I am implementing the termination of the plan in accordance with all applicable laws and regulations; and (2) the information contained in this filing and made available to the Enrolled Actuary is true, correct, and complete. **In making this certification, I recognize that knowingly and willfully making false, fictitious, or fraudulent statements to the PBGC is punishable under 18 U.S.C. §1001.**

Plan Administrator's signature Date Printed name and title of Plan Administrator

# Standard Termination Certification of Sufficiency

**PBGC Schedule EA-S**
**(PBGC Form 500)**
Approved OMB 1212-0036
Expires 11/30/2017

## PART I. IDENTIFYING INFORMATION

| | |
|---|---|
| **1a** Plan Name | **1b** 9-digit employer identification number (EIN) |
| | **1c** 3-digit plan number (PN) |

## PART II. CODE SECTION 412(e)(3) PLANS

**2** Is this plan a Code section 412(e)(3) plan?

☐ No: the Enrolled Actuary must complete Parts III and IV. Item 3 and Part V should not be completed.

☐ Yes: item 3 and Part III must be completed. Depending upon who completes Part III, either Part IV or Part V must be completed and signed by the Plan Administrator or Enrolled Actuary as appropriate.

| | |
|---|---|
| **3a** Enter name (full official name of record) and address of the insurer (Address should include room or suite no.) | **3b** Telephone Number |

## PART III. PLAN SUFFICIENCY

| | | |
|---|---|---|
| **4** | Proposed distribution date | (MM/DD/YYYY) |
| **5** | Is the value of plan assets projected to be sufficient as of the proposed distribution date to provide all plan benefits? If "No," the plan cannot terminate in a standard termination. | ☐ Yes ☐ No |
| **6** | Estimated fair market value of plan assets as of the proposed distribution date | **$** |
| **7** | Estimated present value of plan benefits as of the proposed distribution date | **$** |
| **8** | Estimated total amount of residual assets | **$** |
| **9** | Estimated amount of residual assets to be distributed to the employer | **$** |
| **10** | Estimated amount of residual assets to be distributed to participants and beneficiaries | **$** |
| **11** | Has the plan ever required employee contributions? | ☐ Yes ☐ No |
| **12** | If the amount in item 9 is $1 million or more and if any benefits are to be distributed other than through the purchase of annuity contracts, attach a statement showing interest rate/structure used to value the benefits. | |

## PART IV. ENROLLED ACTUARY CERTIFICATION

I, the Enrolled Actuary, certify that: (1) I have reviewed all plan documents and plan and participant data, and applied all relevant provisions of ERISA and the Internal Revenue Code and regulations promulgated thereunder; (2) to the best of my knowledge and belief, this plan's assets equal or exceed the value of its plan benefits as of the proposed distribution date; and (3) to the best of my knowledge and belief, the information contained in this schedule is true, correct, and complete. **In making this certification, I recognize that knowingly and willfully making false, fictitious, or fraudulent statements to the PBGC is punishable under 18 U.S.C. §1001.**

| | |
|---|---|
| Enrolled Actuary's company's name and address (Address should include room or suite no.) | Enrolled Actuary's Name (Print or type) |
| | Enrollment Number |
| | Telephone Number |
| | E-mail address (optional) |

Enrolled Actuary's signature Date

## PART V. PLAN ADMINISTRATOR CERTIFICATION FOR CODE SECTION 412(e)(3) PLANS

I, the Plan Administrator, certify that, to the best of my knowledge and belief: (1) this plan complies with section 412(e)(3) of the Internal Revenue Code and regulations promulgated thereunder; (2) I have reviewed all plan documents and plan and participant data, and applied all relevant provisions of ERISA and the Code and regulations promulgated thereunder; (3) this plan's assets equal or exceed the value of its plan benefits as of the proposed distribution date; and (4) the information contained in this schedule is true, correct and complete. **In making this certification, I recognize that knowingly and willfully making false, fictitious, or fraudulent statements to the PBGC is punishable under 18 U.S.C. §1001.**

Plan Administrator's signature Date Printed name and title of Plan Administrator

# Standard Termination Designation of Representative

**PBGC Schedule REP-S**
**(PBGC Form 500)**
Approved OMB 1212-0036
Expires 11/30/2017

## PART I. IDENTIFYING INFORMATION

| | |
|---|---|
| **1a** Plan Name | **1b** 9-digit employer identification number (EIN) |
| | **1c** 3-digit plan number (PN) |
| **2a** Plan Administrator's name and address (Address should include room or suite no.) | **2b** Plan Administrator's telephone number |
| | **2c** E-mail address (optional) |

## PART II. DESIGNATION OF REPRESENTATIVE(S)

**3** I, _____, Plan Administrator of the above-named pension plan, hereby appoint the following representative(s) to act on my behalf before the Pension Benefit Guaranty Corporation on all matters (other than those specifically excluded below) relating to the termination of the above-named pension plan:

| | |
|---|---|
| **4a** Representative's name and address (Address should include room or suite no.) | **4b** Telephone number |
| | **4c** E-mail address (optional) |
| **4d** Representative's name and address (Address should include room or suite no.) | **4e** Telephone number |
| | **4f** E-mail address (optional) |

**5** Matters excluded from authority of representative(s). List any specific acts with respect to the plan termination that you are excluding from the acts otherwise authorized in this designation:

## PART III. RETENTION / REVOCATION OF PRIOR DESIGNATION(S)

| | | |
|---|---|---|
| **6a** Have you filed any prior designation(s) of representative(s) for **this** termination? | ☐ Yes | ☐ No |
| **6b** If "Yes," do you want any such prior designation(s) of representative(s) to remain in effect? (Attach a copy of all prior designations that are to remain in effect.) | ☐ Yes | ☐ No |

## PART IV. SIGNATURE OF PLAN ADMINISTRATOR

**NOTE: The PBGC will NOT accept unsigned designations.** *If the Plan Administrator is a board (or similar group) composed of employer and employee representatives, at least one employer representative and one employee representative must sign this form. If the plan does not designate a plan administrator or it designates the plan sponsor or the contributing sponsor as the plan administrator, this form must be signed by an officer of the plan sponsor or contributing sponsor who has the authority to sign on behalf of that entity.*

**In executing this document, I certify that the foregoing is true and correct, and recognize that knowingly and willfully making false, fictitious, or fraudulent statements to the PBGC is punishable under 18 U.S.C. § 1001.**

Plan Administrator's signature | Date | Printed name and title

# Post-Distribution Certification for Standard Termination

**PBGC Form 501**
Approved OMB 1212-0036
Expires 11/30/2017

## PART I. IDENTIFYING INFORMATION

Check here if you previously filed a Form 501 for this plan. ☐ If checked, provide dates of filing(s): _____

| | |
|---|---|
| **1a** Plan Name<br><br>Attach copy of the most recent complete plan document and any amendments to it. | **1b** 9-digit employer identification number (EIN)<br><br>**1c** 3-digit plan number (PN) |
| **2** PBGC case number | 8-digit Case # |

## PART II. DISTRIBUTION INFORMATION

| | |
|---|---|
| **3a** Last distribution date in satisfaction of plan benefits | (MM/DD/YYYY) |
| **3b** Date of receipt of IRS determination letter | (MM/DD/YYYY) |
| **4** Were participants and beneficiaries provided with the name and address of the insurer(s) no later than 45 days before the date of distribution? | ☐ Yes ☐ No |
| **5** Were you able to locate all participants and beneficiaries? If "No," see instructions. | ☐ Yes ☐ No |
| **6a** Has a copy of the annuity contract, certificate, or written notice been provided to each participant and beneficiary receiving benefits in the form of an irrevocable commitment? | ☐ Yes ☐ No ☐ N/A |
| **6b** If "Yes" to 6a, enter the latest date the annuity contract, certificate, or written notice was provided to each participant and beneficiary receiving benefits: If "No" or "N/A", see instructions | (MM/DD/YYYY) |
| **7a** Complete name of record of insurer(s) from whom annuity contracts, if any, have been purchased (Address should include room or suite no.) | **7b** Annuity Contract Number(s) |
| **8a** Name and address of contact for location of plan records (Address should include room or suite no.) | **8b** Telephone number |

**9** Summary of distribution of plan benefits. Attach distribution documents (see instructions).

| Type of Benefit | (1) # of Participants or Beneficiaries | (2) Total Value |
|---|---|---|
| **a** Annuities | | $ |
| **b** Lump sums (including direct transfers and distributions to participants and beneficiaries) | | |
| (1) Consensual | | $ |
| (2) Nonconsensual | | $ |
| **c** (1) Designated benefits paid to PBGC for Missing Participants | | $ |
| (2) Other amounts due to PBGC for Missing Participants | | $ |
| **d** No Distribution | | |
| **e** TOTAL (see instructions) | | $ |

## PART III. PLAN ADMINISTRATOR CERTIFICATION

I, the Plan Administrator, certify that to the best of my knowledge and belief that (1) benefits payable with respect to participants have been calculated and valued correctly in accordance with applicable provisions of ERISA and the regulations thereunder; (2) all plan benefits (through priority category 6 under ERISA Section 4044 and 29 CFR Part 4044) under the plan have been satisfied; (3) plan assets in excess of those needed to satisfy all plan benefits (through priority category 6 under ERISA Section 4044 and 29 CFR Part 4044) have been or will be distributed in accordance with applicable provisions of ERISA and the regulations thereunder; and (4) the information contained in this filing is true, correct, and complete. I further certify that I am aware that records supporting the calculation and valuation of benefits and assets must be kept at least six years after the date this post-distribution certification is filed. **In executing this document, I certify that the foregoing is true and correct, and recognize that knowingly and willfully making false, fictitious, or fraudulent statements to the PBGC is punishable under 18 U.S.C. §1001.**

| | |
|---|---|
| Plan Administrator's company name and address (Address should include room or suite no.) | Telephone number<br><br>E-mail address (optional) |
| | |

Plan Administrator's signature | Date | Printed name and title of Plan Administrator