Standard Termination Notice
Single-Employer Plan Termination

PBGC Form 500
Approved OMB 1212-0036
Expires 09/30/2007

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.)

Sponsor's telephone number

2b 9-digit employer identification number (EIN)

3-digit plan number (PN)

2c 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.

2d 6-digit business code

3a Plan Administrator's name and address (if same as 2a, enter "same"). (Address should include room or suite no.)

Plan Administrator's telephone number

E-mail address (optional)

3b Name and address of person to be contacted for more information (if same as 3a, enter "same"). (Address should include room or suite no.)

Telephone number

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 ☐ No

4b If "Yes," enter the filing date (mo., day, yr.)

5a Is this a multiple-employer plan? ☐ Yes ☐ No

5b If "Yes," attach a list of the names and employer identification numbers of all contributing sponsors

6 Reason for plan termination (if more than one, rank in order of significance, beginning with "1" for the most important):

a	Adverse business conditions	**6a**	
b	Plan administration too costly	**6b**	
c	Plan benefits too costly	**6c**	
d	Restructuring of retirement program	**6d**	
e	Other (specify)	**6e**	

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

a	No change	**7a**	
b	Reorganization as part of bankruptcy or similar proceeding	**7b**	
c	Merger of existing subsidiaries or divisions not involving bankruptcy	**7c**	
d	Sale or closing of subsidiaries or divisions not involving bankruptcy	**7d**	
e	Acquisition by another business	**7e**	
f	Acquisition of another business	**7f**	
g	Liquidation	**7g**	

8	Number of plan participants:		
a	Active participants	**8a**	
b	Retirees or beneficiaries receiving benefits	**8b**	
c	Separated vested participants entitled to benefits	**8c**	
d	Total	**8d**	

9	Estimated percent of currently employed participants covered under the terminated plan you expect to be covered under:		
a	New or existing defined benefit plan, other than cash balance plan	**9a**	%
b	New or existing cash balance plan	**9b**	%
c	New or existing profit-sharing plan	**9c**	%
d	New or existing 401(k) plan	**9d**	%
e	New or existing simplified employee plan	**9e**	%
f	Other new or existing defined contribution plan (specify) ______________	**9f**	%
g	No plan	**9g**	%

10 If item 9a or 9b is greater than zero, will the types and levels of benefits under the new or existing defined benefit plan be substantially the same as under the old plan for all groups of participants? ☐ Yes ☐ No

11a	Proposed termination date	(mo., day, yr.)
11b	Proposed termination date stated in notice of intent to terminate (if different from 11a)	(mo., day, yr.)
12a	Earliest date notices of intent to terminate issued to affected parties	(mo., day, yr.)
12b	Latest date notices of intent to terminate issued to affected parties	(mo., day, yr.)
13	Latest date notices of plan benefits issued to participants or beneficiaries	(mo., day, yr.)

14a Has a formal challenge to the termination been initiated under an existing collective bargaining agreement? ☐ Yes ☐ No ☐ N/A

14b If "Yes," 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

16b If "No," 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 ☐ No

17b If "Yes," was the provision adopted prior to 12-18-1988? ☐ Yes ☐ No

17c If you checked "No" in item 17b, enter:

Adoption date of plan provision	(mo., day, yr.)
Effective date of plan	(mo., day, yr.)

18a Has the plan been involved in a spin-off/termination transaction? ☐ Yes ☐ No

18b If "Yes," have the requirements set forth in the Guidelines been satisfied? ☐ Yes ☐ No ☐ N/A

i) If "Yes," enter date, or latest date, a description of the transaction(s) was issued to participants in the ongoing plan. (mo., day, yr.)

ii) If "Yes," enter date, or latest date, notices of plan benefits were issued to participants in the ongoing plan. (mo., day, yr.)

18c If you checked "No" or "N/A" in item 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	Name and title of Plan Administrator

Standard Termination Certification of Sufficiency

PBGC Schedule EA-S

(PBGC Form 500)
Approved OMB 1212-0036
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Plan Name	9-digit employer identification number (EIN)
	3-digit plan number (PN)

PART I. CODE SECTION 412(i) PLANS

1 Is this plan a Code section 412(i) plan? ☐ Yes ☐ No

- **If "No," the Enrolled Actuary must complete Part II and Part III. Do NOT complete item 2 or Part IV.**
- **If "Yes," item 2 below and all of Part II must be completed, and either Part III or Part IV must be completed and signed by the Plan Administrator or Enrolled Actuary, as appropriate.**

2 Enter name (full official name of record) and address of the insurer (Address should include room or suite no.)

Telephone Number

PART II. PLAN SUFFICIENCY

3	Proposed distribution date	(mo., day, yr.)
4	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
5	Estimated fair market value of plan assets as of the proposed distribution date	$
6	Estimated present value of plan benefits as of the proposed distribution date	$
7	Estimated total amount of residual assets	$
8	Estimated amount of residual assets to be distributed to the employer	$
9	Estimated amount of residual assets to be distributed to participants and beneficiaries	$
10	Has the plan ever required employee contributions?	☐ Yes ☐ No
11	If the amount in item 8 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 III. 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 in punishable under 18 U.S.C. 1001.

Enrolled Actuary's printed name and address
(Address should include room or suite no.)

Enrollment Number

Telephone Number

E-mail address (optional)

Enrolled Actuary's signature Date

PART IV. PLAN ADMINISTRATOR CERTIFICATION FOR CODE SECTION 412(i) PLANS

I, the Plan Administrator, certify that, to the best of my knowledge and belief: (1) this plan complies with section 412(i) 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 in punishable under 18 U.S.C. 1001.

Plan Administrator's signature Date Name and title of Plan Administrator

Standard Termination Designation of Representative

PBGC Schedule REP-S

(PBGC Form 500)
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PART I. IDENTIFYING INFORMATION

1 Plan Name	
2 Employer identification and plan numbers	9-digit employer identification number (EIN)
	3-digit plan number (PN)
3 Plan Administrator's name and address (Address should include room or suite no.)	Plan Administrator's telephone number

PART II. DESIGNATION OF REPRESENTATIVE(S)

4 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:

5a Representative's name and address (Address should include room or suite no.)	Telephone number
	E-mail address (optional)
5b Representative's name and address (Address should include room or suite no.)	Telephone number
	E-mail address (optional)

6 Matters excluded (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)

7a Have you filed any prior designation(s) of representative(s) for **this** termination?	☐ Yes ☐ No
7b 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 Administrator is other than an individual or a board, this form must be signed by an officer of the Plan Administrator who has the authority to do so.*

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.

Signature	Date	Name and title

Signature	Date	Name and title

Post-Distribution Certification for Standard Termination

PBGC Form 501

Approved OMB 1212-0036
Expires 09/30/2007

PART I. IDENTIFYING INFORMATION

1	Plan Name	
2	Employer identification and plan numbers	9-digit employer identification number (EIN) 3-digit plan number (PN)
3	PBGC case number	8-digit Case #
4a	Last distribution date	(mo., day, yr.)
4b	Date of receipt of IRS determination letter	(mo., day, yr.)
5	Were participants and beneficiaries provided with the name and address of the insurer(s) no later than 45 days before the date of distribution? (See page 22 of instructions.)	☐ Yes ☐ No
6	Were you able to locate all participants and beneficiaries? If "No," see instructions.	☐ Yes ☐ No
7a	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 **7b** If "Yes," enter date, or latest date, annuity contracts, certificates, or written notices were provided to participants and beneficiaries:
8	Insurer(s) full office name of record, if any, from whom annuity contracts have been purchased. (Address should include room or suite no.)	Annuity Contract Number(s)
9	Location of plan records (Address should include room or suite no.)	Telephone number

10 Summary of distribution of plan benefits

Form	# of Participants or Beneficiaries	Total Value
a Annuities		$
b Lump sums (including direct transfers and distributions to participants and beneficiaries)		
• Consensual		$
• Nonconsensual		$
c Designated benefits paid to PBGC for Missing Participants		$
d No Distribution		
e TOTAL		$

PART II. PLAN ADMINISTRATOR CERTIFICATION

I, the Plan Administrator, certify that: (1) to the best of my knowledge and belief, benefits payable with respect to participants have been calculated and valued correctly in accordance with applicable provisions of ERISA and the regulations thereunder; (2) to the best of my knowledge and belief, all plan benefits (through priority category 6 under ERISA Section 4044 and 29 CFR Part 4044) under the plan have been satisfied; (3) to the best of my knowledge and belief, 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; (4) to the best of my knowledge and belief, the information contained in this filing is true, correct, and complete; and (5) 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 E-mail address (optional)

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