

# Notice of Merger, Consolidation or Transfer of Plan Assets or Liabilities

(Under section 6058(b) of the Internal Revenue Code)  
File Form 5310-A in duplicate.

See the Who Must File instructions before filing this form.

OMB No. 1545-1225  
Expires 4-30-94

For Agency Use Only

Department of the Treasury  
Internal Revenue Service

The information provided on this form will be read by computer. Therefore page 1 must be typed (except the signature). Please enter information exactly as requested and only in the space provided. Do not type in shaded areas.

- 1a** Name of plan sponsor (employer if single-employer plan) \_\_\_\_\_  
Address (number, street, room, or suite no. (If a P.O. box, see page 1 of the instructions)) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_
- 1b** Employer identification number \_\_\_\_\_
- 1c** Employer's tax year ends—N/A or (MM) \_\_\_\_\_
- 1d** Telephone number \_\_\_\_\_  
( ) \_\_\_\_\_
- 2** Person to be contacted if more information is needed. (If same as 1a, leave blank.)  
(Complete even if Power of Attorney is attached):  
Name \_\_\_\_\_  
Address (number, street, room, or suite no. (If a P.O. box, see page 1 of the instructions)) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_ Telephone number \_\_\_\_\_  
( ) \_\_\_\_\_
- 3a** Name of Plan (Plan name may not exceed 66 characters.): \_\_\_\_\_
- b** Enter plan number (3 digits) \_\_\_\_\_ **d** Enter date plan effective (MMDDYY) \_\_\_\_\_  
**c** Enter date plan year ends (MMDD) \_\_\_\_\_ **e** Enter number of participants in plan \_\_\_\_\_
- 4a** If this is a defined benefit plan, enter the appropriate number in box at left **AND** attach an actuarial statement of valuation showing compliance with the requirements of Code section 401(a)(12) and the regulations under section 414(l).  
Enter 1 for unit benefit Enter 3 for flat benefit  
Enter 2 for fixed benefit Enter 4 for other (specify) \_\_\_\_\_
- b** If this is a defined contribution plan, enter the appropriate number in box at left **AND** attach an actuarial statement of valuation showing compliance with the requirements of Code section 401(a)(12) and the regulations under section 414(l).  
Enter 1 for profit sharing Enter 4 for target benefit  
Enter 2 for stock bonus Enter 5 for other (specify) \_\_\_\_\_  
Enter 3 for money purchase
- 5a** Is the employer a member of an affiliated service group?  
Enter 1 if "Yes" Enter 2 if "No" Enter 3 if "Not Certain"
- b** Is the employer a member of a controlled group of corporations or a group of trades or businesses under common control?  
Enter 1 if "Yes" Enter 2 if "No"
- 6** Enter type of plan:  
Enter 1 if governmental plan or church plan not subject to ERISA  
Enter 2 if multiple employer plan (described in section 413(c)). Enter number of participating employers \_\_\_\_\_  
Enter 3 if other
- 7** Other plan(s) involved in transaction (see instructions):  
**a** Plan name \_\_\_\_\_  
**b** Name of employer \_\_\_\_\_  
**c** Employer Identification number \_\_\_\_\_ **d** Plan number (3 digits) \_\_\_\_\_  
**e** Date of merger, consolidation or transfer (MMDDYY) \_\_\_\_\_  
**f** Type of plan . Enter the number to indicate type of plan: **1** defined benefit, **2** 401(k) arrangement,  
**3** ESOP **4** money purchase, or **5** Other.

Under penalties of perjury, I declare that I have examined this application, including accompanying statements, and to the best of my knowledge and belief it is true, correct, and complete. **Both copies of this page must be signed.**

Signature ►

Title ►

Date ►

For Paperwork Reduction Act Notice, see page 1 of the instructions.

Cat. No. 12783Y

Form **5310-A** (5-91)

< 5310-A >  
< 5/91 >

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**1a** Name of plan sponsor (employer if single-employer plan) **1b** Employer identification number  
< \_\_\_\_\_ > < \_\_\_\_\_ >  
Address (number, street, room, or suite no. (If a P.O. box, see page 1 of the instructions))  
**1c** Employer's tax year ends—N/A or (MM)  
< \_\_\_\_\_ >  
City State ZIP code  
**1d** Telephone number  
< \_\_\_\_\_ > ( )

**2** Person to be contacted if more information is needed. (If same as 1a, leave blank.)  
(Complete even if Power of Attorney is attached):  
Name  
< \_\_\_\_\_ >  
Address (number, street, room, or suite no. (If a P.O. box, see page 1 of the instructions))  
< \_\_\_\_\_ >  
City State ZIP code Telephone number  
< \_\_\_\_\_ > ( )

**3a** Name of Plan (Plan name may not exceed 66 characters.):  
< \_\_\_\_\_ >  
< \_\_\_\_\_ > **b** Enter plan number (3 digits) \_\_\_\_\_ **d** Enter date plan effective (MMDDYY)  
< \_\_\_\_\_ > **c** Enter date plan year ends (MMDD) < \_\_\_\_\_ > **e** Enter number of participants in plan

**4a** If this is a defined benefit plan, enter the appropriate number in box at left **AND** attach an actuarial statement of valuation showing compliance with the requirements of Code section 401(a)(12) and the regulations under section 414(l).  
< \_\_\_\_\_ > Enter 1 for unit benefit Enter 3 for flat benefit  
Enter 2 for fixed benefit Enter 4 for other (specify) \_\_\_\_\_

**b** If this is a defined contribution plan, enter the appropriate number in box at left **AND** attach an actuarial statement of valuation showing compliance with the requirements of Code section 401(a)(12) and the regulations under section 414(l).  
< \_\_\_\_\_ > Enter 1 for profit sharing Enter 4 for target benefit  
Enter 2 for stock bonus Enter 5 for other (specify) \_\_\_\_\_  
Enter 3 for money purchase

**5a** Is the employer a member of an affiliated service group?  
< \_\_\_\_\_ > Enter 1 if "Yes" Enter 2 if "No" Enter 3 if "Not Certain"

**b** Is the employer a member of a controlled group of corporations or a group of trades or businesses under common control?  
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**6** Enter type of plan:  
< \_\_\_\_\_ > Enter 1 if governmental plan or church plan not subject to ERISA  
Enter 2 if multiple employer plan (described in section 413(c)). Enter number of participating employers \_\_\_\_\_  
Enter 3 if other

**7** Other plan(s) involved in transaction (see instructions):  
**a** Plan name < \_\_\_\_\_ >  
**b** Name of employer < \_\_\_\_\_ >  
**c** Employer Identification number < \_\_\_\_\_ > **d** Plan number (3 digits) < \_\_\_\_\_ >  
**e** Date of merger, consolidation or transfer (MMDDYY) < \_\_\_\_\_ >  
**f** Type of plan < \_\_\_\_\_ > . Enter the number to indicate type of plan: **1** defined benefit, **2** 401(k) arrangement, **3** ESOP **4** money purchase, or **5** Other.

Under penalties of perjury, I declare that I have examined this application, including accompanying statements, and to the best of my knowledge and belief it is true, correct, and complete. **Both copies of this page must be signed.**

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