Reporting and Disclosure Guide for Employee Benefit Plans

U.S. Department of Labor
Employee Benefits Security Administration

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October 2003

Introduction

This ***Reporting and Disclosure Guide for Employee Benefit Plans*** has been prepared by the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) with assistance from the Pension Benefit Guaranty Corporation (PBGC). It is intended to be used as a quick reference tool for certain basic reporting and disclosure requirements under the Employee Retirement Income Security Act of 1974 (ERISA). Not all ERISA reporting and disclosure requirements are reflected in this guide. For example, the guide, as a general matter, does not focus on disclosures required by the Internal Revenue Code or the provisions of ERISA for which the Treasury Department and Internal Revenue Service have regulatory and interpretive authority.

The guide contains, on page 15, a list of EBSA and PBGC resources, including agency Internet sites, where laws, regulations, and other guidance are available on ERISA's reporting and disclosure requirements. Readers should refer to the law, regulations, instructions for any applicable form, or other official guidance issued by EBSA or the PBGC for complete information on ERISA's reporting and disclosure requirements.

This guide contains three chapters. The first chapter, beginning on page 2, provides an overview of the most common disclosures that administrators of employee benefit plans are required to furnish to participants, beneficiaries, and certain other individuals under Title I of ERISA. The chapter has three sections: Basic Disclosure Requirements for Pension and Welfare Benefit Plans; Additional Disclosure Requirements for Welfare Benefit Plans That Are Group Health Plans; and Additional Disclosure Requirements for Pension Plans.

The second chapter, beginning on page 7, provides an overview of reporting and disclosure requirements for defined benefit pension plans under Title IV of ERISA. The PBGC administers these provisions. The chapter focuses primarily on single-employer plans and has four sections. The first section - Pension Insurance Premiums - applies to covered single-employer and multiemployer defined benefit plans. The last three sections - Standard Terminations, Distress Terminations, and Other Reports - apply only to covered single-employer defined benefit plans.

The third chapter, beginning on page 10, provides an overview of the Form 5500 and Form M-1 Annual Reporting requirements. The chapter consists of the following quick reference charts: Pension and Welfare Benefit Plan Form 5500 Quick Reference Chart; DFE Form 5500 Quick Reference Chart; and Form M-1 Quick Reference Chart.

This Department of Labor publication is intended to improve public access to information about the reporting and disclosure rules under ERISA. We made every effort to ensure that the information presented is current as of October 1, 2003. This guide, however, does not reflect regulations that have been proposed but not issued in final form as of that date.

Overview of ERISA Title I Basic Disclosure Requirements[1]

Section 1: Basic Disclosure Requirements for Pension and Welfare Benefit Plans

Document	Type of Information	To Whom	When
Summary plan description (SPD)	Primary vehicle for informing participants and beneficiaries about their plan and how it operates. Must be written for average participant and be sufficiently comprehensive to apprise covered persons of their benefits, rights, and obligations under the plan. Must accurately reflect the plan's contents as of the date not earlier than 120 days prior to the date the SPD is disclosed. See 29 CFR §§ 2520.102-2 and 2520.102-3 for style, format, and content requirements.	Participants and those pension plan beneficiaries receiving benefits. (Also see "Plan Documents" below for persons with the right to obtain SPD upon request). See 29 CFR § 2520.102-2(c) for provisions on foreign language assistance when a certain portion of plan participants are literate only in the same non-English language.	Automatically to participants within 90 days of becoming covered by the plan and to pension plan beneficiaries within 90 days after first receiving benefits. However, a plan has 120 days after becoming subject to ERISA to distribute the SPD. Updated SPD must be furnished every 5 years if changes made to SPD information or plan is amended. Otherwise must be furnished every 10 years. See 29 CFR § 2520.104b-2.
Summary of material modification (SMM)	Describes material modifications to a plan and changes in the information required to be in the SPD. Distribution of updated SPD satisfies this requirement. See 29 CFR § 2520.104b-3.	Participants and those pension plan beneficiaries receiving benefits. (Also see "Plan Documents" below for persons with the right to obtain SMM upon request).	Automatically to participants and pension plan beneficiaries receiving benefits; not later than 210 days after the end of the plan year in which the change is adopted.
Summary annual report (SAR)	Narrative summary of the Form 5500. See 29 CFR § 2520.104b-10(d) for prescribed format.	Participants and those pension plan beneficiaries receiving benefits.	Automatically to participants and pension plan beneficiaries receiving benefits within 9 months after end of plan year, or 2 months after due date for filing Form 5500 (with approved extension).
Notification of benefit determination (claims notices or "explanation of benefits")	Information regarding benefit claim determinations. Adverse benefit determinations must include required disclosures (e.g., the specific reason(s) for the denial of a claim, reference to the specific plan provisions on which the benefit determination is based, and a description of the plan's appeal procedures).	Claimants (participants and beneficiaries or authorized claims representatives).	Requirements vary depending on type of plan and type of benefit claim involved. See 29 CFR § 2560.503-1 for prescribed claims procedures requirements.
Plan documents	The plan administrator must furnish copies of certain documents upon written request and must have copies available for examination. The documents include the latest updated SPD, latest Form 5500, trust agreement, and other instruments under which the plan is established or operated.	Participants and beneficiaries. Also see 29 CFR § 2520.104a-8 regarding the Department's authority to request documents.	Copies must be furnished no later than 30 days after a written request. Plan administrator must make copies available at its principal office and certain other locations as specified in 29 CFR § 2520.104b-1(b).

*All footnotes for this chapter are on page 6.

Section 2: Additional Disclosure Requirements for Welfare Benefit Plans That Are Group Health Plans [2]

Document	Type of Information	To Whom	When
Summary of material reduction in covered services or benefits	Summary of group health plan amendments and changes in information required to be in SPD that constitute a "material reduction in covered services or benefits." See 29 CFR § 2520.104b-3(d)(3) for definitions.	Participants.	Generally within 60 days of adoption of material reduction in group health plan services or benefits. See 29 CFR § 2520.104b-3(d)(2) regarding 90-day alternative rule for furnishing the required information.
Initial COBRA notice [3]	Notice of the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event. For more information, see EBSA's booklet ***Health Benefits Under the Consolidated Omnibus Budget Reconciliation Act (COBRA)***.	Covered employees and covered spouses.	When group health plan coverage commences.
COBRA election notice [3]	Notice to "qualified beneficiaries" of their right to elect COBRA coverage upon occurrence of qualifying event. For more information, see EBSA's booklet ***Health Benefits Under the Consolidated Omnibus Budget Reconciliation Act (COBRA)***.	Covered employees, covered spouses, and dependent children who are qualified beneficiaries.	The administrator must provide qualified beneficiaries with this notice, generally within 14 days after being notified by the employer or qualified beneficiary of the qualifying event. The time period for the employer or qualified beneficiary to notify the plan administrator varies depending on the type of qualifying event that has occurred. See ERISA §§ 606(a)(2), 606(a)(3), and 606(a)(4).
Certificate of creditable coverage	Notice from employee's former group health plan documenting prior group health plan creditable coverage. See 29 CFR § 2590.701-5(a)(3)(ii) for information required to be included on the certificate. For more information, see EBSA's ***Compliance Assistance Guide: Recent Changes in Health Care Law*** and the ***New Health Laws Notice Guide***.	Participants and beneficiaries who lose coverage.	Automatically upon losing group health plan coverage, becoming eligible for COBRA coverage, and when COBRA coverage ceases. A certificate may be requested free of charge anytime prior to losing coverage and within 24 months of losing coverage.
General notice of preexisting condition exclusion [4]	Notice describing a group health plan's preexisting condition exclusion and how prior creditable coverage can reduce the preexisting condition exclusion period. See 29 CFR § 2590.701-3(c) for prescribed requirements.	Participants.	Notification must occur before any preexisting condition exclusion may be applied to any individual. Notice may be included in a group health plan's enrollment materials.

Document	Type of Information	To Whom	When
Individualized notice of period of preexisting condition exclusion[4]	Notice that a specific preexisting condition exclusion period applies to an individual upon consideration of creditable coverage evidence and an explanation of appeal procedures if the individual disputes the plan's determination. See 29 CFR § 2590.701-5(d)(2) for prescribed requirements.	Participants and beneficiaries who demonstrate creditable coverage that is not enough to completely offset the preexisting condition exclusion.	Within a reasonable time after participant or covered dependent provides evidence of prior creditable coverage.
Notice of special enrollment rights[4]	Notice describing the group health plan's special enrollment rules including the right to special enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption. See 29 CFR § 2590.701-6(c) for prescribed requirements as well as a model notice.	Employees eligible to enroll in a group health plan.	On or before the time an employee is offered an opportunity to enroll in the group health plan.
Women's Health and Cancer Rights Act (WHCRA) notices[4]	Notice describing required benefits for mastectomy-related reconstructive surgery, prostheses, and treatment of physical complications of mastectomy. For more information, see EBSA's booklet ***Your Rights After A Mastectomy - Women's Health and Cancer Rights Act of 1998***.	Participants and beneficiaries.	Notice must be furnished upon enrollment and annually.
Medical Child Support Order (MCSO) notice	Notification from plan administrator regarding receipt and qualification determination on a MCSO directing the plan to provide health insurance coverage to a participant's noncustodial children. See ERISA § 609(a)(5)(A) for prescribed requirements.	Participants, any child named in a MCSO, and his or her representative.	Administrator, upon receipt of MCSO, must promptly issue notice (including plan's procedures for determining its qualified status). Administrator must also issue separate notice as to whether the MCSO is qualified within a reasonable time after its receipt.
National Medical Support (NMS) notice	Notice used by State agency responsible for enforcing health care coverage provisions in a MCSO. See ERISA § 609(a)(5) and 29 CFR § 2590.609-2 for prescribed requirements. Depending upon certain conditions, employer must complete and return Part A of the NMS notice to the State agency or transfer Part B of the notice to the plan administrator for a determination on whether the notice is a qualified MCSO.	State agencies, employers, plan administrators, participants, custodial parents, children, representatives.	Employer must either send Part A to the State agency, or Part B to plan administrator, within 20 days after the date of the notice or sooner, if reasonable. Administrator must promptly notify affected persons of receipt of the notice and the procedures for determining its qualified status. Administrator must within 40-business days after its date or sooner, if reasonable, complete and return Part B to the State agency and must also provide required information to affected persons. Under certain circumstances, the employer may be required to send Part A to the State agency after the plan administrator has processed Part B.

Section 3: Additional Disclosure Requirements for Pension Plans

Document	Type of Information	To Whom	When
Individual benefit statements	Statements of total accrued benefits and total nonforfeitable pension benefits, if any, which have accrued, or the earliest date on which benefits become nonforfeitable. See ERISA §§ 105 and 209.	Participants and beneficiaries	Requirements vary depending on whether the administrator is responding to a written request for an accrued benefit statement (generally such statements must be furnished within 30 days of the request but no more than once in a 12 month period) or whether the administrator is furnishing the notice automatically due to the occurrence of certain specified events such as certain separations from covered service and certain breaks in service. The requirements also vary depending on whether more than one unaffiliated employer is required to contribute to the plan.
Suspension of benefits notice	Notice that benefit payments are being suspended during certain periods of employment or reemployment. See 29 CFR § 2530.203-3 for prescribed requirements.	Employees whose benefits are suspended.	During first month or payroll period in which the withholding of benefit payments occurs.
Notice of transfer of excess pension assets to retiree health benefit account	Notification of transfer of defined benefit plan excess assets to retiree health benefit account. See ERISA § 101(e) for prescribed requirements.	Employer sponsoring pension plan from which transfer is made must give notice to the Secretaries of Labor and Treasury, each employee organization representing plan participants, and the plan administrator. Plan administrator must notify each participant and beneficiary under the plan.	Notices must be given not later than 60 days before the date of the transfer. The employer notice also must be available for inspection in the principal office of the administrator.
Domestic relations order (DRO) and qualified domestic relations order (QDRO) notices	Notifications from plan administrator regarding its receipt of a DRO, and upon a determination as to whether the DRO is qualified. For more information see ERISA § 206(d)(3) and the EBSA booklet ***QDROs: The Division of Pensions Through Qualified Domestic Relations Orders***.	Participants, and alternate payees (i.e., spouse, former spouse, child, or other dependent of a participant named in a DRO as having a right to receive all or a portion of the participant's plan benefits).	Administrator, upon receipt of the DRO, must promptly issue the notice (including the plan's procedures for determining its qualified status). The second notice, regarding whether the DRO is qualified, must be issued within a reasonable period of time after receipt of the DRO.
Notice of significant reduction in future benefit accruals	Notice of plan amendments to defined benefit plans and certain defined contribution plans that provide for a significant reduction in the rate of future benefit accruals or the elimination or significant reduction in an early retirement benefit or retirement-type subsidy. See 26 CFR § 54.4980F-1 for further information.	Participants, alternate payees under a QDRO, and employee organizations.	Except as provided in regulations prescribed by the Secretary of Treasury, notice must be provided within a reasonable time before the effective date of the plan amendment.

Document	Type of Information	To Whom	When
Notice of failure to meet minimum funding standards	Notification of failure to make a required installment or other plan contribution to satisfy minimum funding standard within 60 days of contribution due date. (Not applicable to multiemployer plans). See ERISA § 101(d) for more information.	Participants, beneficiaries, and alternative payees under QDROs.	Must be furnished within a "reasonable" period of time after the failure. ERISA § 4011 notice, if provided within a reasonable time after the failure, satisfies this requirement. See 60 F.R. 34412 (June 30, 1995). Notice is not required if a funding waiver is requested in a timely manner; if waiver is denied, notice must be provided within 60 days after the denial.
Section 404(c) plan disclosures	Investment-related and certain other disclosures for participant-directed individual account plans described in 29 CFR § 2550.404c-1.	Participants or beneficiaries, as applicable.	Certain information should be furnished to participants or beneficiaries before the time when investment instructions are to be made; certain information must be furnished upon request.
Notice of blackout period for individual account plans	Notification of any period of more than 3 consecutive business days when there is a temporary suspension, limitation or restriction under an individual account plan on directing or diversifying plan assets, obtaining loans, or obtaining distributions.	Participants and beneficiaries of individual account plans affected by such blackout periods and issuers of affected employer securities held by the plan.	Generally at least 30 days but not more than 60 days advance notice. See ERISA § 101(i) and 29 CFR § 2520.101-3 for further information on the notice requirement.

[1] Refer to the Department's regulations and other guidance for information on the extent to which charges may be assessed to cover the cost of furnishing particular information, statements, or documents to participants and beneficiaries required under Title I of ERISA.

[2] The term "group health plan" means an employee welfare plan to the extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

[3] The Department recently published proposed regulations that, if adopted, would make certain changes to the COBRA notice requirements. COBRA generally applies to group health plans of employers who employed 20 or more employees during the prior calendar year. Provisions of COBRA covering State and local government plans are administered by the Department of Health and Human Services. COBRA does not apply to plans sponsored by certain church-related organizations.

[4] For more information, see EBSA's ***Compliance Assistance Guide: Recent Changes in Health Care Law*** and the ***New Health Laws Notice Guide***.

Overview of Basic PBGC Reporting and Disclosure Requirements

Section 1: Pension Insurance Premiums (for covered single-employer and multiemployer defined benefit plans) (ERISA §§ 4006 and 4007; 29 CFR Parts 4006 and 4007)

Document	Type of Information	To Whom	When
Form 1-ES	Estimated flat-rate premium payment (with supporting data) for plans with 500 or more participants in prior plan year.	Pension Benefit Guaranty Corporation (PBGC).	By last day of second full calendar month following end of prior plan year.
Form 1 (with Schedule A for single-employer plans)	Annual premium payment (with supporting data) for all plans except single-employer plans that claim an exemption from the variable-rate premium.	PBGC	By the 15th day of tenth full calendar month following end of prior plan year.
Form 1-EZ	Annual premium payment (with supporting data) for a single-employer plan that claims an exemption from the variable-rate premium.	PBGC	By the 15th day of tenth full calendar month following end of prior plan year.

Section 2: Standard Terminations (for covered single-employer defined benefit plans) (ERISA §§ 4041 and 4050; 29 CFR Parts 4041 and 4050)

Document	Type of Information	To Whom	When
Notice of Intent to Terminate	Advises of proposed termination and provides information about the termination process.	Participants, beneficiaries, alternate payees, and union.	At least 60 and no more than 90 days before proposed termination date. (If possible insurers not known at this time, supplemental notice no later than 45 days before distribution date.)
Form 500 - Standard Termination Notice	Advises of proposed termination and provides plan data.	PBGC	No later than 180 days after proposed termination date.
Notice of Plan Benefits	Provides information on each person's benefits.	Participants, beneficiaries, and alternate payees.	No later than the time Form 500 (Standard Termination Notice) is filed with PBGC.
Form 501 - Post-Distribution Certification	Certifies that distribution of plan assets has been properly completed.	PBGC	No later than the 30th day after distribution of plan assets completed. (PBGC will not assess a penalty if filed within 90 days of distribution deadline.)
Schedule MP - Missing Participants	Advises of a participant or beneficiary under a terminating plan whom the plan administrator cannot locate.	PBGC	Filed with Form 501. (See above for time limits.)

Section 3: Distress Terminations (for covered single-employer defined benefit plans) (ERISA §§ 4041 and 4050; 29 CFR Parts 4041 and 4050)

Document	Type of Information	To Whom	When
Form 600 - Distress Termination Notice of Intent to Terminate	Advises of proposed termination and provides plan and sponsor data.	PBGC	At least 60 days and (except with PBGC approval) no more than 90 days before proposed termination date.
Notice of Intent to Terminate to Affected Parties Other than PBGC	Advises of proposed termination and provides information about the termination process.	Participants, beneficiaries, alternate payees, and union.	No later than the time Form 600 (Notice of Intent to Terminate) is filed with PBGC.
Notice of Request to Bankruptcy Court to Approve Termination	Advises of sponsor's/controlled group member's request to Bankruptcy Court to approve plan termination based upon reorganization test.	PBGC	Concurrent with request to Bankruptcy Court.
Form 601 - Distress Termination Notice, Single-Employer Plan Termination	Demonstrates satisfaction of distress criteria, and provides plan and sponsor/controlled group data.	PBGC	No later than the 120th day after the proposed termination date.
Form 602 - Post-Distribution Certification for Distress Termination	Certifies the distribution of plan assets has been properly completed for a plan that is sufficient for guaranteed benefits.	PBGC	No later than the 30th day after distribution of plan assets completed. (PBGC will not assess a penalty if filed within 90 days of distribution deadline.)
Schedule MP - Missing Participants	Advises of a participant or beneficiary under a terminating plan whom the plan administrator cannot locate. (This assumes plan is sufficient for guaranteed benefits.)	PBGC	Filed with Form 602. (See above for the time limits.)

Section 4: Other Reports (for covered single-employer defined benefit plans)

Document	Type of Information	To Whom	When
Form 10 - Post-Event Notice of Reportable Events	Requires submission of information relating to event, plan, and controlled group for: failure to make a required minimum funding payment, active participant reduction, change in contributing sponsor or controlled group, application for funding waiver, liquidation, bankruptcy, and various other events. See ERISA § 4043 and 29 CFR Part 4043.	PBGC	No later than 30 days after plan administrator or contributing sponsor knows (or has reason to know) the event has occurred.
Form 10-Advance - Advance Notice of Reportable Events	Requires submission of information relating to event, plan, and controlled group for: change in contributing sponsor or controlled group, liquidation, loan default, transfer of benefit liabilities, and various other events. This requirement applies to privately held controlled groups with plans having aggregate unfunded vested benefits over $50 million and an aggregate funded vested percentage under 90 percent. See ERISA § 4043 and 29 CFR Part 4043.	PBGC	At least 30 days in advance of effective date of event.
Form 200 - Notice of Failure to Make Required Contributions	Requires submission of information relating to plan and controlled group where plan has aggregate missed contributions of more than $1 million. See ERISA § 302(f)(4) and 29 CFR Part 4043, subparts A and D.	PBGC	No later than 10 days after contribution due date.
Annual Financial and Actuarial Information Reporting	Requires submission of actuarial and financial information for controlled groups where: unfunded vested benefits of all plans maintained by the group exceed $50 million (disregarding those plans with no unfunded vested benefits), a plan's minimum funding waiver(s) exceed(s) $1 million, or the group is subject to a lien for missed contributions to a plan (if not paid within 10 days). See ERISA § 4010 and 29 CFR Part 4010.	PBGC	No later than 105 days after the close of the filer's information year, with a possible extension for certain required actuarial information until 15 days after filing deadline for annual report (Form 5500).
Participant Notice	Advises of underfunded plan's funding status and limits on PBGC's guarantee. See ERISA § 4011 and 29 CFR Part 4011.	Participants, beneficiaries, alternate payees, and union.	No later than 2 months after filing deadline for Form 5500 for previous plan year.

Overview of Form 5500 and Form M-1 Annual Reporting Requirements

Form 5500 Annual Reporting Requirements

EBSA, in conjunction with the Internal Revenue Service (IRS) and the PBGC, publishes the Form 5500 Annual Return / Report forms used by plan administrators to satisfy various annual reporting obligations under ERISA and the Internal Revenue Code (Code).

The Form 5500 is filed and processed under the ERISA Filing Acceptance System (EFAST). There are two formats for filing the Form 5500. The first format, "machine print," is completed using computer software from EFAST-approved vendors and can be filed electronically or by mail, including certain private delivery services. The other format, "hand print," may be completed by typewriter, by hand, or by using computer software from EFAST approved vendors, and may be filed only by mail, including certain private delivery services.

The Form 5500 filing requirements vary according to the type of filer. There are three general types of filers: small plans (generally plans with fewer than 100 participants as of the beginning of the plan year); large plans (generally plans with 100 or more participants as of the beginning of the plan year); and direct filing entities (DFEs). DFEs are trusts, accounts, and other investment or insurance arrangements that plans participate in and that are required to or allowed to file the Form 5500 directly with EBSA. These investment and insurance arrangements include master trust investment accounts (MTIAs), common / collective trusts (CCTs), pooled separate accounts (PSAs), 103-12 investment entities (103-12 IEs), and group insurance arrangements (GIAs). MTIAs are the only DFE for which the filing of the Form 5500 is mandatory. Employee benefit plans that participate in CCTs, PSAs, 103-12 IEs, and GIAs that file as DFEs are eligible for certain annual reporting relief.

Certain employee benefit plans are exempt from the annual reporting requirements or are eligible for limited reporting options. The major classes of plans exempt from filing an annual report or eligible for limited reporting are described in the Form 5500 instructions.

The Form 5500 filed by plan administrators and GIAs are due by the last day of the 7th calendar month after the end of the plan or GIA year (not to exceed 12 months in length). See the Form 5500 instructions for information on extensions. The Form 5500 filed by DFEs other than GIAs are due no later than $9^{1/2}$ months after the end of the DFE year.

Two quick reference charts immediately follow this section and describe the basic filing requirements for small plans, large plans, and DFEs. The two charts are: Pension and Welfare Benefit Plan Form 5500 Quick Reference Chart on pages 11 and 12, and DFE Form 5500 Quick Reference Chart on page 13. Check the EFAST Internet site at ***www.efast.dol.gov*** and the latest Form 5500 instructions for information on who is required to file, how to complete the forms, when to file, EFAST approved software, and electronic filing options.

Form M-1 Annual Reporting Requirements

Administrators of multiple employer welfare arrangements (MEWAs) and certain other entities that offer or provide coverage for medical care to employees of two or more employers are generally required to file the Form M-1 (Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)). The Form M-1 is filed with EBSA. The Form M-1 is due no later than March 1, following any calendar year for which a filing is required. A quick reference chart on Reporting Requirements for MEWAs and ECEs is on page 14. Also, check the EBSA Internet site at ***www.dol.gov/ebsa*** for more information on the Form M-1.

Section 1: Pension and Welfare Benefit Plan Quick Reference Chart: Form 5500, Schedules and Attachments [1]

	Large Pension Plan	Small Pension Plan	Large Welfare Plan	Small Welfare Plan
Form 5500	Must complete. [2]	Must complete. [2]	Must complete.	Must complete. [3]
Schedule A - Insurance Information	Must complete if plan has insurance contracts for benefits or investments.	Must complete if plan has insurance contracts for benefits or investments.	Must complete if plan has insurance contracts for benefits or investments.	Must complete if plan has insurance contracts for benefits[3] or investments.
Schedule B - Actuarial Information	Must complete if defined benefit plan and subject to minimum funding standards. [4]	Must complete if defined benefit plan and subject to minimum funding standards. [4]	Not required.	Not required.
Schedule C - Service Provider Information	Must complete if service provider was paid $5,000 or more or an accountant or enrolled actuary was terminated.	Not required.	Must complete if service provider was paid $5,000 or more or an accountant or enrolled actuary was terminated.	Not required.
Schedule D - DFE / Participating Plan Information	Must complete Part I if a plan participates in a CCT, PSA, MTIA, or 103-12 IE.	Must complete Part I if a plan participates in a CCT, PSA, MTIA, or 103-12 IE.	Must complete Part I if a plan participates in a CCT, PSA, MTIA, or 103-12 IE.	Must complete Part I if a plan participates in a CCT, PSA, MTIA, or 103-12 IE.
Schedule E - ESOP Annual Information	Must complete if ESOP.	Must complete if ESOP.	Not required.	Not required.
Schedule G - Financial Transaction Schedules	Must complete if Schedule H, lines 4b, 4c, or 4d are required to be marked "Yes." [5]	Not required.	Must complete if Schedule H, lines 4b, 4c, or 4d are required to be marked "Yes." [5, 6]	Not required.
Schedule H - Large Plan and DFE Financial Information	Must complete. [2, 5]	Not required.	Must complete. [5, 7]	Not required.
Schedule I - Small Plan Financial Information	Not required.	Must complete. [2]	Not required.	Must complete. [3]
Schedule P - Annual Return of Fiduciary of Employee Benefit Trust	Must file to start running of statute of limitations under Code § 6501(a).	Must file to start running of statute of limitations under Code § 6501(a).	Not required.	Not required.

*See footnotes for certain exemptions and other technical requirements. All footnotes for this section are on page 12.

	Large Pension Plan	Small Pension Plan	Large Welfare Plan	Small Welfare Plan
Schedule R - Retirement Plan Information	Must complete, unless exempt.[8]	Must complete, unless exempt.[8]	Not required.	Not required.
Schedule SSA - Annual Registration Statement Identifying Separated Participants with Deferred Vested Benefits	Must complete if plan had separated participants with deferred vested benefits to report.	Must complete if plan had separated participants with deferred vested benefits to report.	Not required.	Not required.
Schedule T - Qualified Pension Plan Coverage Information	Must complete if tax-qualified plan unless permitted to rely on coverage testing information for prior year.	Must complete if tax-qualified plan unless permitted to rely on coverage testing information for prior year.	Not required.	Not required.
Independent Qualified Public Accountant's Report	Must attach.[2, 9]	Not required unless Schedule I, line 4k, is checked "No."[9]	Must attach.[7, 9]	Not required.

[1] This chart provides only general guidance and not all rules and requirements are reflected. Refer to specific Form 5500 instructions for complete information on filing requirements.
[2] Pension plans are exempt from filing any schedules and the independent qualified public accountant's report if the plan uses a Code section 403(b)(1) annuity and / or 403(b)(7) custodial account, or 408 individual retirement account or annuity as the sole funding vehicle for providing benefits. Pension benefit plans providing benefits exclusively through an insurance contract or contracts that are fully guaranteed and that meet all of the conditions of 29 § CFR 2520.104-44(b)(2) during the entire plan year are exempt from filing Schedule H, Schedule I, and the independent qualified public accountant's report.
[3] Unfunded, fully insured and combination unfunded / insured welfare plans covering fewer than 100 participants at the beginning of the plan year that meet the requirements of 29 CFR § 2520.104-20 are exempt from filing an annual report.
[4] Must also complete if filed for a money purchase defined contribution plan required to amortize a waiver of the minimum funding requirements.
[5] Must also complete schedules of assets and reportable (5 percent) transactions if Schedule H, lines 4i or 4j, are marked "yes," but use of computer scannable form is not required.
[6] Must also complete to report any nonexempt transactions even if Schedule H is not required.
[7] Unfunded, fully insured and combination unfunded / insured welfare plans covering 100 or more participants at the beginning of the plan year that meet the requirements of 29 CFR § 2520.104-44 are exempt from the accountant's report requirement and completing Schedule H.
[8] Must complete if defined benefit plan or plan is otherwise subject to minimum funding requirements. Certain other pension plans also may be required to complete this schedule. See Schedule R instructions for further explanation.
[9] For information on the requirements for deferring an accountant's report pursuant to 29 CFR § 2520.104-50 in connection with a short plan year of 7 months or less and the contents of the required explanatory statement, see the Form 5500 instructions.

Section 2: DFE Quick Reference Chart: Form 5500, Schedules and Attachments [1]

	MTIA	CCT OR PSA	103-12 IE	GIA
Form 5500	Must complete. [2]	Must complete if filing as a DFE. [2]	Must complete if filing as a DFE. [2]	Must complete if filing as a DFE. [2]
Schedule A - Insurance Information	Must complete if MTIA has insurance contracts.	Not required.	Must complete if 103-12 IE has insurance contracts.	Must complete.
Schedule C - Service Provider Information	Must complete Part I if service provider was paid $5,000 or more. Part II not required.	Not required.	Must complete Part I if service provider was paid $5,000 or more and Part II if an accountant was terminated.	Must complete Part I if service provider was paid $5,000 or more and Part II if an accountant was terminated.
Schedule D - DFE / Participating Plan Information	List all plans that participated in the MTIA in Part II. List all CCTs, PSAs, and 103-12 IEs in which the MTIA participated or invested during the MTIA year in Part I.	List all plans that participated in the CCT or PSA in Part II. List all CCTs, PSAs, and 103-12 IEs in which the CCT or PSA participated or invested during the CCT or PSA year in Part I.	List all plans that participated in the 103-12 IE in Part II. List all CCTs, PSAs, and 103-12 IEs in which the 103-12 IE participated or invested during the 103-12 IE year in Part I.	List all plans that participated in the GIA in Part II. List all CCTs, PSAs and 103-12 IEs in which the GIA participated or invested during the GIA year in Part I.
Schedule G - Financial Transaction Schedules	Must complete if Schedule H, lines 4b, 4c, or 4d, are required to be checked "Yes."	Not required.	Must complete if Schedule H, lines 4b, 4c, or 4d, are required to be checked "Yes."	Must complete if Schedule H, lines 4b, 4c, or 4d, are required to be checked "Yes."
Schedule H - Large Plan and DFE Financial Information	Must complete Parts I, II, III, and IV.	Must complete Parts I, II, and III. Skip Part IV.	Must complete Parts I, II, III, and IV.	Must complete Parts I, II, III, and IV.
Schedules of Assets and Reportable (5 percent) Transactions	Must complete if Schedule H, lines 4i or 4j, are required to be checked "Yes." See Schedule H instructions.	Not required.	Must complete Schedules of Assets if Schedule H, line 4i, is required to be checked "Yes." Schedule of Reportable (5 percent) Transactions not required. See Schedule H instructions.	Must complete if Schedule H, lines 4i or 4j, are required to be checked "Yes." See Schedule H instructions.
Independent Qualified Public Accountant's Report	Not required.	Not required.	Must attach.	Must attach.

[1] This chart provides only general guidance and not all rules and requirements are reflected. Refer to specific Form 5500 instructions for complete information on filing requirements.
[2] An MTIA is the only DFE for which the filing of the Form 5500 is mandatory. Employee benefit plans that participate in CCTs, PSAs, 103-12 IEs, and GIAs that file as DFEs are eligible for certain annual reporting relief.

Section 3: MEWAs and ECEs Quick Reference Chart: Form M-1[1]

Document	Type of Information	To Whom	When
Form M-1 Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)	MEWA or ECE identifying information. States in which coverage is provided, insurance information, number of participants covered, and information about compliance with Part 7 of ERISA, including any litigation alleging non-compliance. Administrators of MEWAs and ECEs that offer or provide coverage for medical care to employees of two or more employers (including one or more self-employed individuals) are generally required to file the Form M-1. An ECE is an entity that claims it is not a MEWA due to the exception in the definition of MEWA for entities that are established and maintained under or pursuant to one or more agreements that the Secretary of Labor finds to be collective bargaining agreements. For more information on this exception, see 29 CFR § 2510.3-40.	EBSA	***Annual Report:*** By March 1st of the year following calendar year for which report is required. An extension until May 1st is available. For ECEs, an annual report is required to be filed only if the ECE was last originated within 3 years before annual filing due date. ***Origination Report:*** Due within 90 days of origination. "Origination" generally means: (1) the MEWA or ECE first begins offering or providing coverage; (2) the MEWA or ECE begins offering or providing coverage after a merger (unless all MEWAs or ECEs involved in the merger were last originated at least 3 years prior to the merger); or (3) the number of employees to which the MEWA offers or provides coverage has grown at least 50 percent.

[1] This chart provides only general guidance and not all rules and requirements are reflected.

EBSA Resources

For more information about EBSA's reporting and disclosure requirements, contact:

U.S. Department of Labor
Employee Benefits Security Administration
Division of Technical Assistance and Inquiries
200 Constitution Ave., N.W.
Washington, DC 20210
(202) 219-8776
Web site: www.dol.gov/ebsa

For assistance on completing the Form 5500, call the EFAST Help Line at ***1-866-463-3278***.

For assistance on completing the Form M-1, call ***(202) 693-8360***.

The following publications may be helpful in providing a more detailed explanation on specific subject matter:

Health Benefits Under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

Provides a general explanation of the COBRA right to purchase a temporary extension of group health insurance.

Your Rights After A Mastectomy: Women's Health and Cancer Rights Act of 1998

Explains the rules applicable to group health plans that offer mastectomy coverage.

QDROs: The Division of Pensions Through Qualified Domestic Relations Orders

Addresses the division of pension assets during divorce or legal separation.

Troubleshooter's Guide to Filing the ERISA Annual Report (Form 5500)

Focuses on how to avoid common reporting errors.

Compliance Assistance Guide: Recent Changes in Health Care Law and ***New Health Laws Notice Guide***

These two separate guides describe the obligations of group health plans and group health insurance issuers under Part 7 of Title I of ERISA, including provisions of the Health Insurance Portability and Accountability Act. The guides also include sample language that may be used to meet disclosure requirements.

These and other EBSA publications may be obtained from:

Toll-free number: 1- 866-444-EBSA (3272)
Web site: www.dol.gov/ebsa

PBGC Resources

For information about PBGC's reporting and disclosure requirements, call ***1-800-736-2444*** or ***(202) 326-4242***.

For premium-related questions, write to:

Pension Benefit Guaranty Corporation
P.O. Box 64916
Baltimore, MD 21264-4916

For questions on other topics such as plan terminations and reportable events, write to:

Pension Benefit Guaranty Corporation
Standard Termination Compliance Division/
Processing and Technical Assistance Branch
1200 K St., N.W., Suite 930
Washington, DC 20005-4026

Web site: www.pbgc.gov