Reporting and Disclosure Guide for Employee Benefit Plans

This publication has been developed by the U.S. Department of Labor, Employee Benefits Security Administration (EBSA).

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Reporting and Disclosure Guide for Employee Benefit Plans

U.S. Department of Labor
Employee Benefits Security Administration

September 2017

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 Department of the Treasury and Internal Revenue Service (IRS) have regulatory and interpretive authority. For more information on IRS notice and disclosure requirements, please visit the IRS Website at **irs.gov/Retirement-Plans/Retirement-Plan-Reporting-and-Disclosure**.

The guide contains, on page 23, 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 Retirement and Welfare Benefit Plans; Additional Disclosure Requirements for Welfare Benefit Plans That Are Group Health Plans; and Additional Disclosure Requirements for Retirement Plans.

The second chapter, beginning on page 15, 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 Reportable Events and Other Reports - apply only to covered single-employer defined benefit plans.

The third chapter, beginning on page 18, 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 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. It has been updated as of September 2017. Please be sure to check for current laws and regulations on the reporting and disclosure provisions included in this publication on EBSA's Website at **dol.gov/agencies/ebsa**

Overview of ERISA Title I Basic Disclosure Requirements[1*]

Section 1: Basic Disclosure Requirements for Retirement 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. For plan years beginning after December 31, 2007, the SAR is no longer required for defined benefit pension plans to which Title IV applies, and which now instead provide the annual funding notice (see below).	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 8.

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.
COBRA General Notice[3]	Notice of the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event. See 29 CFR § 2590.606-1. For more information, visit **dol.gov/agencies/ebsa/laws-and-regulations/laws/COBRA**. A model notice is available at **dol.gov/agencies/ebsa/laws-and-regulations/laws/COBRA/model-general-notice.doc**.	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 as well as information about other coverage options available, such as through the Marketplace. See 29 CFR § 2590.606-4. For more information, visit **dol.gov/agencies/ebsa/laws-and-regulations/laws/COBRA.** A model notice is available at **dol.gov/agencies/ebsa/laws-and-regulations/laws/COBRA/model-election-notice.doc.**	Covered employees, covered spouses, and dependent children who are qualified beneficiaries.	The administrator must generally provide qualified beneficiaries with this notice, generally within 14 days after being notified by the employer or qualified beneficiary of the qualifying event. If the employer is also the plan administrator, the administrator must provide the notice not later than 44 days after: the date on which the qualifying event occurred; or if the plan provides that COBRA continuation coverage starts on the date of loss of coverage, the date of loss of coverage due to a qualifying event.
Notice of Unavailability of COBRA	Notice that an individual is not entitled to COBRA coverage. See 29 CFR § 2590.606-4(c).	Individuals who provide notice to the administrator of a qualifying event whom the administrator determines are not eligible for COBRA coverage.	The administrator must provide this notice generally within 14 days after being notified by the individual of the qualifying event.
Notice of Early Termination of COBRA Coverage	Notice that a qualified beneficiary's COBRA coverage will terminate earlier than the maximum period of coverage. See 29 CFR § 2590.606-4(d).	Qualified beneficiaries whose COBRA coverage will terminate earlier than the maximum period of coverage.	As soon as practicable following the administrator's determination that coverage will terminate.
Medical Child Support Order (MCSO) Notice	Notification from plan administrator regarding receipt and qualification determination on a MCSO directing the plan to provide health 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.

Document	Type of Information	To Whom	When
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.
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.	At or before the time an employee is initially offered the opportunity to enroll in the group health plan.
Employer CHIPRA Notice	Employer (rather than plan) must inform employees of possible premium assistance opportunities available in the state they reside. A model notice is available at **dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra**. See 75 FR 5808-11 for more prescribed requirements.	All employees regardless of enrollment or eligibility status.	Notice must be furnished annually.
Wellness Program Disclosure[4]	Notice given by any group health plan offering a health contingent wellness program in order to obtain a reward. The notice must disclose the availability of a reasonable alternative standard (or possibility of waiver of the otherwise applicable standard). Disclosure must include contact information for obtaining the alternative and a statement that recommendations of an individual's personal physician will be accommodated. See 29 CFR § 2590.702(f)(2)(v) for prescribed requirements as well as model language.	Participants and beneficiaries eligible to participate in a health contingent wellness program in order to obtain a reward.	In all plan materials that describe the terms of a health contingent wellness program (both activity-only and outcome-based wellness programs). For outcome-based wellness programs, this notice must also be included in any disclosure that an individual did not satisfy an initial outcome-based standard. If the plan materials merely mention that a program is available, without describing its terms, this disclosure is not required.

Document	Type of Information	To Whom	When
Newborns' Act Description of Rights[4]	Notice must include a statement describing any requirements under federal or state law that relate to a hospital length of stay in connection with childbirth. If the federal law applies in some areas in which the plan operates and state law applies in other areas, the SPD should describe the federal or state requirements applicable to each area. See 29 CFR § 2520.102-3(u) for prescribed requirements as well as model language.	Participants.	Notice must be included in the Summary Plan Description.
Michelle's Law Enrollment Notice	Must include a description of the Michelle's Law provision for continued coverage during medically necessary leaves of absence. See ERISA section 714(c).	Participants and beneficiaries.	Notice must be included with any notice regarding a requirement for certification of student status for coverage under the plan. Note: Under the Affordable Care Act, plans cannot deny or restrict coverage for a child under the age of 26 based on student status.
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.	Participants.	Notice must be furnished upon enrollment and annually.
Mental Health Parity and Addiction Equity Act (MHPAEA) Criteria for Medically Necessary Determination Notice	Notice must provide beneficiaries the criteria for medically necessary determinations with respect to mental health/substance use disorder benefits. See 29 CFR § 2590.712(d)(1).	Any current or potential participant, beneficiary or contracting provider.	Notice must be provided upon request.
MHPAEA Claims Denial Notice	Notice must provide the reason for any denial of reimbursement or payment for services with respect to mental health/ substance use disorder benefits. See 29 CFR § 2590.712(d)(2).	Participant or beneficiaries.	Notice must be provided upon request or as otherwise required by other laws.
MHPAEA Increased Cost Exemption	A group health plan claiming MHPAEA's increased cost exemption must furnish a notice of the plan's exemption from the parity requirements. See 29 CFR § 2590.712(g)(6).	Participants, beneficiaries, EBSA and state regulators.	Notice must be provided if using the cost exemption.
Grandfathered Plan Disclosure/Notice[4]	Notice must disclose that the plan is grandfathered and must include contact information. See 29 CFR § 2590.715-1251(a)(2).	Participants and beneficiaries.	Notice must be included in any plan materials describing the benefits or health coverage.

Document	Type of Information	To Whom	When
Summary of Benefits and Coverage (SBC) and Uniform Glossary	A template that describes the benefits and coverage under the plan, and a uniform glossary defining statutorily and NAIC recommended terms. See 29 CFR § 2590.715-2715(a) and (c). The required SBC template is available at **dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-template.pdf** and the Uniform Glossary is available at **dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms.pdf.** The SBC must include an Internet address where an individual can review the Uniform Glossary as well as contact information for obtaining a paper copy.	Plans (provided by group health insurance issuers). Participants and beneficiaries.	SBC must be provided to participants and beneficiaries with enrollment materials and upon renewal or reissuance of coverage. SBC must also be provided to special enrollees no later than the date by which an SPD is required to be provided (90 days from enrollment). The SBC and a copy of the Uniform Glossary must also be provided upon request within 7 days.
Summary of Benefits and Coverage: Notice of Modification	If a plan makes a material modification in any of the plan terms that would affect the content of the SBC that is not reflected in the most recently provided SBC, the plan must provide notice of such change. This does not apply to changes that occur in connection with a renewal or reissuance. See 29 CFR § 2590.715-2715(b).	Participants and beneficiaries.	Notice must be provided no later than 60 days prior to the date on which the modification will become effective.
Notice Regarding Designation of a Primary Care Provider [4]	If a non-grandfathered plan requires a participant or beneficiary to designate a primary care provider, the plan must provide notice of the terms of the plan or coverage regarding designation of a primary care provider and participants' rights to designate any participating primary care provider who is available to accept the participant; with respect to a child to designate any participating physician who specializes in pediatrics; and that the plan may not require authorization or referral for OB/GYN care by a participating OB/GYN professional. See 29 CFR § 2590.715-2719A(a)(4). Model language is available at **dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/patient-protection-model-notice.doc**.	Participants.	Notice must be provided with the Summary Plan Description or any other similar description of benefits.

Document	Type of Information	To Whom	When
Internal Claims and Appeals and External Review Notices [4]	Internal Claims and Appeals: Non-grandfathered plans must provide notice of adverse benefit determination and notice of final internal adverse benefit determination. See 29 CFR § 2590.715-2719(b)(2)(ii)(E) for specific content requirements. Model notices are available at • **dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/revised-model-notice-of-adverse-benefit-determination.doc** • **dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/revised-model-notice-of-final-internal-adverse-benefit-determination.doc** External Review: After an external review, the independent review organization (IRO) will issue a notice of final external review decision. See state law, Technical Release 2010-01 or 29 CFR § 2590.715-2719 (c) and (d) for prescribed requirements. Model notice for the federal process under the Technical Release and final rule are available at **dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/revised-model-notice-of-final-external-review-decision.doc**.	For internal claims and appeals, the notices are provided to claimants. For Federal external review pursuant to the Technical Release, the notices are provided by the IRO to claimants and plan.	For internal claims and appeals, timing of the notices vary based on the type of claim. For external review the timing of the notice may vary based on the type of claims and whether the state or the federal process applies. See 29 CFR § 2590.715-2719 for more information.
External Review Process Disclosure	Non-grandfathered plans must provide a description of the external review process in or attached to the summary plan description, policy, certificate, or other evidence of coverage provided to participants, beneficiaries, or enrollees. See Technical Release 2011-02 and 29 CFR § 2590.715-2719(c) for more information.	Participants and beneficiaries.	The description of external review processes must be provided in the summary plan description or other evidence of coverage provided to enrollees.

Document	Type of Information	To Whom	When
EBSA Form 700	EBSA Form 700 is a form used when an organization wishes to claim an accommodation with respect to the requirement to cover certain contraceptive services without cost sharing. Other methods to invoking an accommodation, such as providing a notice to the Secretary of HHS, are also available. EBSA Form 700 is available online at: **dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/coverage-of-preventive-services**. Information about providing notice to HHS is available online at **dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/model-notice-to-secretary-of-hhs.pdf**.	EBSA Form 700 is provided by the organization or its plan to the plan's health insurance issuer or third party administrator. Notice to the Secretary of HHS should be sent by email or U.S. mail to HHS.	
Employer Notice to Employees of Coverage Options	Employers subject to the Fair Labor Standards Act must provide a written notice informing the employee of the existence of the Marketplace, the potential availability of a tax credit and that an employee may lose the employer contribution if the employee purchases a qualified health plan. See Technical Release 2013-02 and FLSA 18B for prescribed requirements. A model notice is available at **dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/coverage-options-notice.**	Must be provided by the employer to all employees regardless of plan eligibility or part-time or full-time status.	Notice must be provided to all new employees.

[1] Please 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. See, e.g., 29 CFR § 2520.104b-30.
[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] 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: Health Benefits Coverage Under Federal Law***.

Section 3: Additional Disclosure Requirements for Retirement Plans

Document	Type of Information	To Whom	When
Periodic Pension Benefit Statement	Content of statements varies depending on the type of plan. In general, all statements must indicate total benefits and total nonforfeitable pension benefits, if any, which have accrued, or earliest date on which benefits become nonforfeitable. Benefit statements for an individual account plan must also provide the value of each investment to which assets in the individual account have been allocated. Benefit statements for individual account plans that permit participant investment direction must also include an explanation of any limitation or restriction on any right of the participant or beneficiary under the plan to direct an investment; an explanation of the importance of a well-balanced and diversified portfolio, including a statement of the risk that holding more than 20 percent of a portfolio in the security of an entity (such as employer securities) may not be adequately diversified; and a notice directing the participant or beneficiary to the Internet Website of the Department of Labor for sources of information on individual investing and diversification. See ERISA § 105.	Participants and beneficiaries	In general, at least once each quarter for individual account plans that permit participants to direct their investments; at least once each year, in the case of individual account plans that do not permit participants to direct their investments; and at least once every three years in case of defined benefit plans or, in the alternative, defined benefit plans can satisfy this requirement if at least once each year the administrator provides notice of the availability of the pension benefit statement and the ways to obtain such statement. In addition, the plan administrator of a defined benefit plan must furnish a benefit statement to a participant or beneficiary upon written request, limited to one request during any 12-month period. In addition, the plan administrator of an individual account plan must furnish a benefit statement upon request to a beneficiary that does not receive statements automatically, limited to one request during any 12-month period.
Statement of Accrued and Nonforfeitable Benefits	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 § 209.	Participants	The plan administrator shall provide a statement to participants upon request, upon termination of service with the employer, or after the participant has a 1-year break in service. Not more than one statement shall be required in any 12-month period for statements provided upon request. Not more than one statement shall be required with respect to consecutive 1-year breaks in service.

Document	Type of Information	To Whom	When
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 the 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 Retirement Benefits 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, contributing employers, and certain employee organizations.	Except as provided in regulations prescribed by the Secretary of the Treasury, notice must be provided within a reasonable time, generally 45 days, before the effective date of a plan amendment subject to ERISA. See § 204(h) of ERISA and IRC § 4980F.
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. 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, including blackout notice for participant-directed individual account plans described in ERISA section 404(c)(1)(A)(ii), as described below. Special rules apply for qualified investment options under ERISA section 404(c)(4)(C).	Participants and 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.

Document	Type of Information	To Whom	When
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.
Qualified Default Investment Alternative Notice*	Advance notice to participants and beneficiaries describing the circumstances under which contributions or other assets will be invested on their behalf in a qualified default investment alternative, the investment objectives of the qualified default investment alternative, and the right of participants and beneficiaries to direct investments out of the qualified default investment alternative. See 29 CFR § 2550.404c-5. See also ERISA § 514(e)(3).	Participants and beneficiaries on whose behalf an investment in a QDIA may be made.	An initial notice must be furnished at least 30 days in advance of the date of plan eligibility, or at least 30 days in advance of the date of any first investment in a qualified default investment alternative on behalf of a participant or beneficiary; or on or before the date of plan eligibility if the participant has the opportunity to make a permissible withdrawal within the first 90 days. Further, there is an annual notice requirement within a reasonable period of time of at least 30 days in advance of each subsequent plan year. See 29 CFR § 2550.404c-5.
Automatic Contribution Arrangement Notice*	A plan administrator of an automatic contribution arrangement shall provide a notice under ERISA § 514(e)(3). Generally, this notice shall inform participants of their rights and obligations under the arrangement.	Each participant to whom the arrangement applies. See ERISA § 514(e)(3).	The plan administrator of an automatic contribution arrangement shall, within a reasonable period before such plan year, provide the notice. See ERISA § 514(e)(3).
Annual Funding Notice	Basic information about the status and financial condition of the defined benefit pension plan, including the plan's funding percentage; assets and liabilities; demographic information regarding active, retired and separated from service participants; the funding policy; endangered, critical or critical and declining status; explanation of events having a material effect on liabilities or assets; rules on termination or insolvency; a description of the benefits guaranteed by the PBGC; annual report information; information disclosed to the PBGC, if applicable; and any additional information the plan administrator elects to include. See ERISA § 101(f) and 29 CFR § 2520.101-5.	Participants, beneficiaries receiving benefits, alternate payees receiving benefits, labor organizations representing participants under the plan, each employer of a multiemployer plan that is a party to a collective bargaining agreement pursuant to which a plan is maintained or who would be subject to withdrawal liability, and the PBGC.	Not later than 120 days after the plan year for large plans. Small plans (100 or fewer participants on each day during the plan year preceding the notice year) must furnish the notice no later than the earlier of the date on which the annual report is filed or the latest date the annual report must be filed (including extensions).

* Use of the IRS sample Automatic Enrollment Notice posted on the IRS website may be used to satisfy these two notice requirements. See Field Assistance Bulletin 2008-03, Question 8.

Document	Type of Information	To Whom	When
Multiemployer Plan Summary Report	Certain financial information, such as contribution schedules, benefit formulas, number of employers obligated to contribute, number of participants on whose behalf no contributions were made for a specified period of time, number of withdrawing employers, and withdrawal liability. See ERISA § 104(d).	Each employee organization and to each employer that has an obligation to contribute to the plan.	Within 30 days after the due date of the annual report.
Multiemployer Pension Plan Information Made Available on Request	Copies of periodic actuarial reports, quarterly, semi-annual, or annual financial reports, and amortization extension applications. See ERISA § 101(k), and 29 CFR § 2520.101-6.	Participants, beneficiaries receiving benefits, each labor organization representing participants under the plan, and each employer that has an obligation to contribute to the plan.	Within 30 days of written request. Requester not entitled to receive more than one copy of any report or application during any 12-month period. See ERISA § 101(k).
Multiemployer Plan Notice of Potential Withdrawal Liability	Estimated amount of employer's withdrawal liability and how such estimated liability was determined. See ERISA § 101(l).	Any employer who has an obligation to contribute to the plan.	Generally, within 180 days of a written request.
Notice of Funding-based Limitation	The plan administrator of a single-employer or multiple employer defined benefit plan must provide a notice of specified funding-based limits on benefit accruals and benefit distributions. See ERISA § 101(j).	Participants and beneficiaries.	Generally, within 30 days after a plan becomes subject to a specified funding-based limitation, as well as at any other time determined by the Secretary of the Treasury. See IRS Notice 2012-46.
Notice of Right to Divest	Notice of right to sell company stock and reinvest proceeds into other investments available under the plan. Notice also must describe the importance of diversifying the investment of retirement account assets. See ERISA § 101(m). IRS Notice 2006-107 provides a model notice.	Participants, alternate payees with accounts under the plan, and beneficiaries of deceased participants. See ERISA § 204(j).	Not later than 30 days before the first date on which the individuals are eligible to exercise their rights. See ERISA § 101(m).
Disclosures required for the Fiduciary Safe Harbor for Automatic Rollovers to Individual Retirement Plans for Certain Mandatory Distributions Exceeding $1,000	In order to qualify for the safe harbor, a plan fiduciary must furnish to participants a summary plan description (SPD) or a summary of material modifications (SMM) that describes the plan's automatic rollover provisions, including an explanation that if a participant is subject to mandatory distribution and fails to make an election regarding a form of benefit distribution, the participant's account balance will be rolled over into an individual retirement plan. See 29 CFR § 2550.404a-2.	Separating participants subject to mandatory distributions under the Internal Revenue Code.	The disclosure by SPD or SMM must be provided before mandatory distributions are made, and will be sufficient if provided in conjunction with the notice required under Code section 402(f) which must be provided to a plan participant no less than 30 days and no more than 180 days before the date of a distribution. See IRS Notice 2009-68.

Document	Type of Information	To Whom	When
Notice of Plan Termination pursuant to the Safe Harbor for Distributions from Terminated Individual Account Plans	A plan fiduciary (including a qualified termination administrator) must provide a notice to participants and beneficiaries of the plan's termination and distribution options and procedures to make an election. In addition, the notice must provide information about the account balance; explain, if known, what fees, if any, will be paid from the participant or beneficiary's retirement plan; and provide the name, address and telephone number of the individual retirement plan provider, if known, and of the plan administrator or other fiduciary from whom information about the termination may be obtained. See 29 CFR § 2550.404a-3.	Participants or beneficiaries in terminated individual account plans.	The notice will be given during the winding up process of the plan termination. Participants and beneficiaries have 30 days from the receipt of the notice to elect a form of distribution.
Notice of Critical or Endangered Status	The sponsor of a multiemployer defined benefit pension plan must provide notice if the plan is in critical or endangered status (a plan in critical and declining status is a plan in critical status) because of funding or liquidity problems. The notice must include an explanation of the possibility that certain adjustable benefits may be reduced. See IRC § 432.	Participants, beneficiaries, the bargaining parties, PBGC, and the Department of Labor.	Not later than 30 days after the plan actuary's annual certification, if the actuary certifies that the plan is in critical or endangered status. For a model critical status notice, see **dol.gov/agencies/ebsa/about-ebsa/our-activities/public-disclosure/critical-status-notices**.
Participant Plan and Investment Fee Disclosures	The plan administrator must furnish information about the administrative and investment costs of participation in 401(k)-type plans. This includes general information about the mechanics and structure of the plan, such as how to give investment directions, and information about the plan's administrative costs (e.g., recordkeeping, legal) and individual charges that may be assessed to participants (for loans, QDROs, etc.). This also includes a comparative chart with information about the plan's investment options, including investment fees and expenses, performance and benchmark data, an active Website address with supplemental investment information, and a glossary of terms to assist participants in understanding the plan's investment options. See 29 CFR § 2550.404a-5.	Generally, participants and beneficiaries with the authority to direct their own investments in individual account plans.	General information about the plan and potential administrative and individual costs, as well as a "comparative chart" of key information about plan investment options, must be furnished annually (at least once in any 14 month period). On at least a quarterly basis, participants must receive a statement of the dollar amount of administrative and individual fees that were charged to their accounts. This information may, in certain circumstances, be included in the plan's SPD and participants' Periodic Pension Benefit Statements.

Document	Type of Information	To Whom	When
Plan Service Provider Disclosures	Certain plan service providers must provide detailed information about the compensation, both direct and indirect, that they will receive for providing services to pension plans. Service providers also may have to furnish information to assist plans in complying with other ERISA reporting and disclosure requirements (e.g., Form 5500 Annual Report, Participant Plan and Investment Fee Disclosures). See 29 CFR § 2550.408b-2(c) for definitions of which service providers must comply and the specific disclosures that must be furnished.	Plan fiduciaries responsible for hiring pension plan service providers.	Generally, disclosure must be furnished to the plan fiduciary reasonably in advance of entering into a contract or arrangement with the service provider. See 29 CFR § 2550.408b-2(c) for provisions on when changes or updates to previously disclosed information must be furnished by the service provider.

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
Comprehensive Premium Filing	Annual premium payment (with supporting data) for all plans.	PBGC	By the 15th day of the 10th calendar month that begins on or after the 1st day of the premium payment 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. (If PBGC assesses a penalty, it will do so only to the extent the form is filed more than 90 days after distribution deadline, including extensions.)
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.)

*To electronically submit premium filings and payments to the PBGC, use PBGC's online application, My Plan Administration Account (My PAA). My PAA and more information can be found at the PBGC's Website (**pbgc.gov**) on the page for Practitioners under Premium Filings.

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, demonstrates satisfaction of distress criteria, and provides plan and sponsor/controlled group 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.
Disclosure of Termination Information	A plan administrator must disclose information it has submitted to PBGC in connection with a distress termination. See ERISA § 4041(c)(2). (Note that a plan administrator or a plan sponsor must disclose information it has submitted to PBGC in connection with a PBGC-initiated termination. See ERISA § 4042(c)(3).)	Participants, beneficiaries, alternate payees, and union.	No later than 15 business days after (1) receipt of a request from the affected party for the information; or (2) the provision of new information to the PBGC relating to a previous request.
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 (and Schedule EA-D) - Distress Termination Notice, Single-Employer Plan Termination	Provides information on the plan and sufficiency of plan assets to provide benefits.	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. (If PBGC assesses a penalty, it will do so only to the extent the form is filed more than 90 days after the distribution deadline, including extensions.)
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: Reportable Events and 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, loan default, 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. (Extensions may apply)
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.
Reporting of Substantial Cessation of Operation and of Withdrawal of Substantial Employer	Advises PBGC of certain cessations of operation and of withdrawals of substantial employers and requests determination of liability. See ERISA §§ 4062(e) and 4063(a).	PBGC	No later than 60 days after event.
Annual Financial and Actuarial Information Reporting	Requires submission of actuarial and financial information for certain controlled groups with substantial underfunding. 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).

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

Form 5500 Annual Reporting Requirements

The Department of Labor, in conjunction with the Internal Revenue Service (IRS) and the PBGC, publishes the Form 5500 Annual Return/Report of Employee Benefit Plan and the Form 5500-SF Short Form Annual Return/Report of Small Employee Benefit Plan. The Form 5500 series is used by plan administrators and certain "direct filing entities" to satisfy various annual reporting obligations under ERISA and the Internal Revenue Code (Code).

Direct filing entities, or DFEs, are investment or insurance arrangements that plans participate in and that are required to or allowed to file the Form 5500 directly with EBSA. DFEs include master trust investment accounts (MTIAs), bank common/collective trusts (CCTs), insurance 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 a CCT, PSA, 103-12 IE, or GIA that files a Form 5500 as a DFE are eligible for certain annual reporting relief in connection with the plan's own Form 5500 filing requirement.

All Forms 5500 and Forms 5500-SF must be filed electronically using the ERISA Filing Acceptance System (EFAST2). Filers may file online using EFAST2's Web-based IFILE filing system, or filers may file through an EFAST2-approved vendor. All delinquent and amended filings of Title I plans must also be submitted electronically through EFAST2. More information about electronic filing under EFAST2 is available at **efast.dol.gov**.

The Form 5500 filing requirements vary according to the type of filer. There are three general types of Form 5500 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). The Form 5500-SF is a simplified version of the Form 5500 that certain small plans may be eligible to file instead of the Form 5500. A quick reference chart for the 2016 Form 5500 immediately follows this section and describes the basic Form 5500 filing requirements for small plans, large plans, and DFEs. It also contains a description of the type of small plan that may be eligible to file the Form 5500-SF.

The Form 5500-EZ cannot be submitted electronically through EFAST2. However, a "one-participant" plan (see the instructions for the Form 5500-SF) that is eligible to file the Form 5500-EZ may elect to file the Form 5500-SF electronically with EFAST2 rather than filing a Form 5500-EZ on paper with the IRS. For more information on filing the Form 5500-EZ on paper with the IRS, see the instructions for the Form 5500-EZ, at **irs.gov**, or call **1-877-829-5500**.

The Form 5500 and the Form 5500-SF filed by plan administrators and the Form 5500 filed by 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 and the Form 5500-SF instructions for information on extensions up to an additional 2½ months. The Form 5500 filed by DFEs other than GIAs are due no later than 9½ months after the end of the DFE year.

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 and the Form 5500-SF instructions. All welfare plans required to file Form M-1, *Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)*, must file an annual report in the Form 5500 Annual Return/Report series regardless of plan size or type of funding. See 78 Fed. Reg. 13781, 13796, 13899 (Mar. 1, 2013).

Check the EFAST2 Internet site at **efast.dol.gov** and the latest Form 5500 and Form 5500-SF instructions for information on who is required to file, how to complete the forms, when to file, EFAST2-approved software, and electronic filing options. You can also visit **dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500** to view the Form 5500 and the Form 5500-SF. Schedules and instructions are also posted on that web page.

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 must be filed electronically using the M-1 Online Filing System at **askebsa.dol.gov/mewa**. The Frequently Asked Questions about the M-1 include information on how new users can set up an account. A quick reference chart on Reporting Requirements for MEWAs and ECEs is on page 22. Also, check the EBSA Internet site at **askebsa.dol.gov/mewa** for more information on the Form M-1.

Quick Reference Chart of Form 5500, Schedules, and Attachments (See Footnote 3 for Form 5500-SF Filers)[1*]

	Large Pension Plan	Small Pension Plan[2]	Large Welfare Plan	Small Welfare Plan[2]	DFE
Form 5500	Must complete.	Must complete.	Must complete.[3]	Must complete.[3]	Must complete.
Schedule A (Insurance Information)	Must complete if plan has insurance contracts.	Must complete if plan has insurance contracts.[4]	Must complete if plan has insurance contracts.	Must complete if plan has insurance contracts.[4]	Must complete if MTIA, 103-12 IE, or GIA has insurance contracts.
Schedule C (Service Provider Information)	Must complete Part I if service provider was paid $5,000 or more, Part II if a service provider failed to provide information necessary for the completion of Part I, and Part III if an accountant or actuary was terminated.	Not required.	Must complete Part I if service provider was paid $5,000 or more, Part II if a service provider failed to provide information necessary for the completion of Part I, and Part III if an accountant or actuary was terminated.	Not required.	MTIAs, GIAs, and 103-12 IEs must complete Part I if service provider paid $5,000 or more, and Part II if a service provider failed to provide information necessary for the completion of Part I. GIAs and 103-12 IEs must complete Part III if accountant was terminated.
Schedule D (DFE/ Participating Plan Information)	Must complete Part I if plan participated in a CCT, PSA, MTIA, or 103-12 IE.	Must complete Part I if plan participated in a CCT, PSA, MTIA, or 103-12 IE.[4]	Must complete Part I if plan participated in a CCT, PSA, MTIA, or 103-12 IE.	Must complete Part I if plan participated in a CCT, PSA, MTIA, or 103-12 IE.[4]	All DFEs must complete Part II, and DFEs that invest in a CCT, PSA, or 103-12 IE must also complete Part I.
Schedule G (Financial Schedules)	Must complete if Schedule H, lines 4b, 4c, or 4d are "Yes."	Not required.	Must complete if Schedule H, lines 4b, 4c, or 4d are "Yes."[3]	Not required.[3]	Must complete if Schedule H, lines 4b, 4c, or 4d for a GIA, MTIA, or 103-12 IE are "Yes."
Schedule H (Financial Information)	Must complete.[5]	Not required.	Must complete.[3, 5]	Not required.	All DFEs must complete Parts I, II, and III. MTIAs, 103-12 IEs, and GIAs must also complete Part IV.[5]
Schedule I (Financial Information)	Not required.	Must complete.[4]	Not required.	Must complete.[4]	Not required.

*See footnotes for certain exemptions and other technical requirements. All footnotes for this chart are on page 21.

	Large Pension Plan	Small Pension Plan[2]	Large Welfare Plan	Small Welfare Plan[2]	DFE
Schedule MB (Actuarial Information)	Must complete if multiemployer defined benefit plan or money purchase plan subject to minimum funding standards.[6]	Must complete if multiemployer defined benefit plan or money purchase plan subject to minimum funding standards.[6]	Not required.	Not required.	Not required.
Schedule R (Pension Plan Information)	Must complete.[7]	Must complete.[4, 7]	Not required.	Not required.	Not required.
Schedule SB (Actuarial Information)	Must complete if single-employer or multiple-employer defined benefit plan, including an eligible combined plan and subject to minimum funding standards.	Must complete if single-employer or multiple-employer defined benefit plan, including an eligible combined plan and subject to minimum funding standards.	Not required.	Not required.	Not required.
Accountant's Report	Must attach.	Not required unless Schedule I, line 4k, is checked "No."	Must attach.[3]	Not required.	Must attach for a GIA or 103-12 IE.

[1] This chart provides only general guidance. Not all rules and requirements are reflected. Refer to specific Form 5500 instructions for complete information on filing requirements (e.g., *Who Must File* and *What To File*). For example, a pension plan is exempt from filing any schedules if the plan uses Code section 408 individual retirement accounts as the sole funding vehicle for providing benefits. See *Limited Pension Plan Reporting*.

[2] Pension plans and welfare plans with fewer than 100 participants at the beginning of the plan year that are not exempt from filing an annual return/report may be eligible to file the Form 5500-SF, a simplified report. In addition to the limitation on the number of participants, a Form 5500-SF may only be filed for a plan that is exempt from the requirement that the plan's books and records be audited by an independent qualified public accountant (but not by reason of enhanced bonding), has 100 percent of its assets invested in certain secure investments with a readily determinable fair market value, holds no employer securities, and is not a multiemployer plan. See *Who Must File*.

[3] Unfunded, fully insured, or combination unfunded/fully 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. See *Who Must File*. Such a plan with 100 or more participants must file an annual report, but is exempt under 29 CFR 2520.104-44 from the accountant's report requirement and completing Schedule H, but MUST complete Schedule G, Part III, to report any nonexempt transactions. See *What to File*. All Plans required to file Form M-1, *Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)* must file a Form 5500 regardless of plan size or type of funding.

[4] Do not complete if filing the Form 5500-SF instead of the Form 5500.

[5] Schedules of assets and reportable (5%) transactions also must be filed with the Form 5500 if Schedule H, line 4i or 4j is "Yes."

[6] Money purchase defined contribution plans that are amortizing a funding waiver are required to complete lines 3, 9, and 10 of the Schedule MB in accordance with the instructions. Also see instructions for line 5 of Schedule R and line 12a of Form 5500-SF.

[7] Schedule R should not be completed when the Form 5500 annual return/report is filed for a pension plan that uses, as the sole funding vehicle for providing benefits, individual accounts or annuities (as described in Code section 408). See the Form 5500 instructions for Limited Pension Plan Reporting for more information.

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 custodial and financial information, states in which coverage is provided, insurance information, number of participants covered, information about enforcement actions, 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:** Generally due by March 1st of the year following the calendar year for which report is required. A 60-day extension is available. For ECEs, an annual report is required to be filed only if the ECE was last originated within the 3 years before the annual filing due date. **MEWA Registration:** Generally due upon the following five events, should they occur: 30 days prior to operating in any state; within 30 days of knowingly operating in any additional state or states that were not indicated on a previous Form M-1 filing; within 30 days of operating with regard to the employees of an additional employer (or employers, including one or more self-employed individuals) after a merger with another MEWA; within 30 days of the date the number of employees receiving coverage for medical care under the MEWA is at least 50 percent greater than the number of such employees on the last day of the previous calendar year; or within 30 days of experiencing a material change as defined in the Form M-1 instructions. A MEWA may have to register more than once during the reporting year. **ECE Origination:** Generally due upon the following three events, should they occur: 30 days prior to operating with regard to the employees of two or more employers (including one or more self-employed individuals); within 30 days from when ECE begins operating following a merger with another ECE (unless all of the ECEs that participate in the merger previously were last originated at least three years prior to the merger); or within 30 days from when the number of employees receiving coverage for medical care under the ECE is at least 50 percent greater than the number of such employees on the last day of the previous calendar year (unless the increase is due to a merger with another ECE under which all ECEs that participate in the merger were last originated three years prior to the merger). An ECE may be originated more than once during the reporting year. **ECE Special Filing:** Due within 30 days of a special filing event described below, only if the ECE was last originated within three years before a special filing event: the ECE begins knowingly operating in any additional state or states that were not indicated on a previous Form M-1 filing; or the ECE experiences a material change as defined in the Form M-1 instructions. An ECE may experience a special filing event more than once during the reporting year.

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