
Federal Deposit Insurance Corporation
DECLARATION FOR HEALTH AND WELFARE PLAN

INSTRUCTIONS: Please type or print all information legibly and sign.

Financial Institution: _____

Closing Date: _____

Account Number: _____

Group Number: _____

1. The undersigned is (are) _____ (s) of the _____ Plan ("Plan") for which the above Account (the "Account") was established.

2. The Plan is a welfare plan that provides medical, dental, life insurance and/or similar benefits to participants.

3. The Plan had at least _____ participants on the closing date.

4. The value of all the Plan assets on the closing date was \$ _____ .

5. Are any death benefits paid from assets of the Plan? This does not include any death benefits to be paid from insurance purchased by the Plan to fund death benefits. Yes No

If "Yes," please state the maximum death benefit payable from the Plan assets \$ _____.

6. Were claims for benefits submitted by participants on or before the closing date which were to be paid from assets of the Plan, but had not been paid as of the closing date? This does not include any claims for benefits which were to be paid from insurance purchased by the Plan to provide such benefits. Yes No

If "Yes," please attach as Exhibit A, listing the name of each participant and the amount of benefit to be paid to the participant.

7. The above account is an investment of general Plan assets, which is made on behalf of all the participants in the Plan, and not on behalf of one or more selected participants. Not applicable.

8. This declaration is made to induce the Federal Deposit Insurance Corporation to pay insurance covering the Account(s), to the extent that the Account(s) is (are) covered by insurance.

9. This declaration, under penalty of perjury, is executed pursuant to 28 U.S.C. §1746.

I declare under penalty of perjury that the foregoing is true and correct. Executed on _____ .

Signature of Trustee

Signature of Trustee

THE PENALTY FOR KNOWINGLY MAKING OR INVITING RELIANCE ON ANY FALSE, FORGED OR COUNTERFEIT STATEMENT, DOCUMENT OR THING FOR THE PURPOSE OF INFLUENCING IN ANY WAY THE ACTION OF THE FEDERAL DEPOSIT INSURANCE CORPORATION IS A FINE OF NOT MORE THAN \$1,000,000 OR IMPRISONMENT FOR NOT MORE THAN THIRTY YEARS OR BOTH (18 U.S.C. § 1007).

PAPERWORK REDUCTION ACT NOTICE

The information collected is required for the determination of insured deposits when a financial institution closes in accordance to Deposit Insurance Rules and Regulations. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Paper Reduction Act Clearance Officer, Legal Division, Room MB-3082, Federal Deposit Insurance Corporation, 550 17th Street, N.W., Washington, D.C. 20429. Any agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.