Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2010

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report;
- [ ] the final return/report;
- [ ] an amended return/report;
- [ ] a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
PENSION PLAN FOR SALARIED EMPLOYEES OF METAL TECHNOLOGY SOLUTIONS, INC.

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 09/01/2001

2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
METAL TECHNOLOGY SOLUTIONS, INC.

1775 LOGAN AVENUE
YOUNGSTOWN, OH 44505

2b Employer Identification Number (EIN)
52-2337203

2c Sponsor's telephone number
330-740-8581

2d Business code (see instructions)
332110

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/17/2011	CHRISTOPHER ZETS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
METAL TECHNOLOGY SOLUTIONS, INC.

1775 LOGAN AVENUE
YOUNGSTOWN, OH 44505

3b Administrator's EIN
52-2337203

3c Administrator's telephone number
330-740-8581

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:

a Sponsor's name

4b EIN

4c PN

5	Total number of participants at the beginning of the plan year	**5**	97
6	Number of participants as of the end of the plan year (welfare plans complete only lines **6a, 6b, 6c,** and **6d**).		
a	Active participants	**6a**	28
b	Retired or separated participants receiving benefits	**6b**	26
c	Other retired or separated participants entitled to future benefits	**6c**	37
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	91
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	4
f	Total. Add lines **6d** and **6e**	**6f**	95
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	0
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
1A 1G 1I 3H

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

9a Plan funding arrangement (check all that apply)

(1)	X	Insurance
(2)		Code section 412(e)(3) insurance contracts
(3)		Trust
(4)		General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1)	X	Insurance
(2)		Code section 412(e)(3) insurance contracts
(3)		Trust
(4)		General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

(1)	X	**R** (Retirement Plan Information)
(2)		**MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
(3)	X	**SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

(1)			**H** (Financial Information)
(2)	X		**I** (Financial Information – Small Plan)
(3)	X	1	**A** (Insurance Information)
(4)	X		**C** (Service Provider Information)
(5)	X		**D** (DFE/Participating Plan Information)
(6)			**G** (Financial Transaction Schedules)

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2010

This Form is Open to Public Inspection

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A Name of plan
PENSION PLAN FOR SALARIED EMPLOYEES OF METAL TECHNOLOGY SOLUTIONS, INC.

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500.
METAL TECHNOLOGY SOLUTIONS, INC.

D Employer Identification Number (EIN)
52-2337203

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
04-1590850	65935	SA12787	95	01/01/2010	12/31/2010

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
10449	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
BAIRD INSURANCE SERVICES
777 E WISCONSIN AVE
MILWAUKEE, WI 53202

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
-891	0		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MORGAN STANLEY & CO. INC
HARBORSIDE FINANCIAL
PLAZA TWO 7TH FLOOR
JERSEY CITY, NJ 07311

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
11145	0		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

MORGAN STANLEY INS SERVICES INC.
34 EXCHANGE PLACE
JERSEY CITY, NJ 07311

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
195	0		4

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	0
5	Current value of plan's interest under this contract in separate accounts at year end	5	6032534

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY

b	Balance at the end of the previous year			7b	0
c	Additions: (1) Contributions deposited during the year	7c(1)	0		
	(2) Dividends and credits	7c(2)	0		
	(3) Interest credited during the year	7c(3)	0		
	(4) Transferred from separate account	7c(4)	0		
	(5) Other (specify below)	7c(5)	0		
	▶				
	(6) Total additions			7c(6)	0
d	Total of balance and additions (add **b** and **c(6)**)			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	0		
	(2) Administration charge made by carrier	7e(2)	0		
	(3) Transferred to separate account	7e(3)	0		
	(4) Other (specify below)	7e(4)	0		
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract **e(5)** from **d**)			7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance
e ☐ Temporary disability (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug
i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in **c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			**10b**	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☐ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE SB (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Single-Employer Defined Benefit Plan Actuarial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

OMB No. 1210-0110

2010

This Form is Open to Public Inspection

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of $1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan
PENSION PLAN FOR SALARIED EMPLOYEES OF METAL TECHNOLOGY SOLUTIONS, INC.

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF
METAL TECHNOLOGY SOLUTIONS, INC.

D Employer Identification Number (EIN)
52-2337203

E Type of plan: [X] Single [ ] Multiple-A [ ] Multiple-B

F Prior year plan size: [ ] 100 or fewer [X] 101-500 [ ] More than 500

Part I Basic Information

1	Enter the valuation date: Month 01 Day 01 Year 2010			
2	Assets:			
a	Market value	**2a**		5599710
b	Actuarial value	**2b**		5685173
3	Funding target/participant count breakdown		**(1)** Number of participants	**(2)** Funding Target
a	For retired participants and beneficiaries receiving payment	**3a**	24	3454598
b	For terminated vested participants	**3b**	34	1480126
c	For active participants:			
	(1) Non-vested benefits	**3c(1)**		9921
	(2) Vested benefits	**3c(2)**		2321351
	(3) Total active	**3c(3)**	39	2331272
d	Total	**3d**	97	7265996
4	If the plan is at-risk, check the box and complete items (a) and (b) [ ]			
a	Funding target disregarding prescribed at-risk assumptions	**4a**		
b	Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor	**4b**		
5	Effective interest rate	**5**		6.70 %
6	Target normal cost	**6**		0

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE

Signature of actuary	Date: 10/06/2011
KELLY R. SWART	11-05429
Type or print name of actuary	Most recent enrollment number
BUCK CONSULTANTS, LLC	412-281-2506
Firm name	Telephone number (including area code)
500 GRANT STREET, SUITE 2900 PITTSBURGH, PA 15219-2513	
Address of the firm	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions [ ]

Part II Beginning of year carryover and prefunding balances

		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (Item 13 from prior year)	0	0
8	Portion used to offset prior year's funding requirement (Item 35 from prior year)	0	0
9	Amount remaining (Item 7 minus item 8)	0	0
10	Interest on item 9 using prior year's actual return of 25.76 %		
11	Prior year's excess contributions to be added to prefunding balance:		
	a Excess contributions (Item 38 from prior year)		0
	b Interest on (a) using prior year's effective rate of 8.19 %		0
	c Total available at beginning of current plan year to add to prefunding balance		0
	d Portion of (c) to be added to prefunding balance		0
12	Reduction in balances due to elections or deemed elections	0	0
13	Balance at beginning of current year (item 9 + item 10 + item 11d – item 12)	0	0

Part III Funding percentages

14	Funding target attainment percentage	14	78.24 %
15	Adjusted funding target attainment percentage	15	78.24 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	90.65 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and liquidity shortfalls

18 Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
04/15/2010	8383				
07/15/2010	8383				
10/15/2010	8383				
01/14/2011	8383				
09/15/2011	84895				
			Totals ► 18(b)	118427	18(c) 0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contribution from prior years.	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	108145

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? [X] Yes [ ] No

b If 20a is "Yes," were required quarterly installments for the current year made in a timely manner? [X] Yes [ ] No

c If 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of Quarter of this plan year

(1) 1st	(2) 2nd	(3) 3rd	(4) 4th
0	0	0	0

Part V Assumptions used to determine funding target and target normal cost

21 Discount rate:

a Segment rates:

1st segment:	2nd segment:	3rd segment:	
5.03 %	6.73 %	6.82 %	☐ N/A, full yield curve used

b Applicable month (enter code) **21b** 4

22 Weighted average retirement age **22** 65

23 Mortality table(s) (see instructions) ☐ Prescribed - combined ☒ Prescribed - separate ☐ Substitute

Part VI Miscellaneous items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. ..... ☐ Yes ☒ No

25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. ..... ☒ Yes ☐ No

26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment ..... ☒ Yes ☐ No

27 If the plan is eligible for (and is using) alternative funding rules, enter applicable code and see instructions regarding attachment **27**

Part VII Reconciliation of unpaid minimum required contributions for prior years

28 Unpaid minimum required contribution for all prior years **28** 0

29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (item 19a) **29** 0

30 Remaining amount of unpaid minimum required contributions (item 28 minus item 29) **30** 0

Part VIII Minimum required contribution for current year

31 Target normal cost, adjusted, if applicable (see instructions) **31** 0

32 Amortization installments:	Outstanding Balance	Installment
a Net shortfall amortization installment	1290183	108145
b Waiver amortization installment	0	0

33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount **33**

34 Total funding requirement before reflecting carryover/prefunding balances (item 31 + item 32a + item 32b – item 33) **34** 108145

	Carryover balance	Prefunding balance	Total balance
35 Balances used to offset funding requirement	0	0	0

36 Additional cash requirement (item 34 minus item 35) **36** 108145

37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (Item 19c) **37** 108145

38 Interest-adjusted excess contributions for current year (see instructions) **38** 0

39 Unpaid minimum required contribution for current year (excess, if any, of item 36 over item 37) **39** 0

40 Unpaid minimum required contribution for all years **40** 0

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2010** **This Form is Open to Public Inspection.**

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A Name of plan
PENSION PLAN FOR SALARIED EMPLOYEES OF METAL TECHNOLOGY SOLUTIONS, INC.

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
METAL TECHNOLOGY SOLUTIONS, INC.

D Employer Identification Number (EIN)
52-2337203

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . ☐ Yes ☒ No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

MASSACHUSETTS MUTUAL LIFE INS. CO.

04-1590850

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
52 63 68 72	CONTRACT ADMINISTRATOR	0	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	**(c)** Relationship to employer, employee organization, or person known to be a party-in-interest	**(d)** Enter direct compensation paid by the plan. If none, enter -0-.	**(e)** Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	**(f)** Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	**(g)** Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	**(h)** Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	**(c)** Relationship to employer, employee organization, or person known to be a party-in-interest	**(d)** Enter direct compensation paid by the plan. If none, enter -0-.	**(e)** Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	**(f)** Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	**(g)** Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	**(h)** Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	**(c)** Relationship to employer, employee organization, or person known to be a party-in-interest	**(d)** Enter direct compensation paid by the plan. If none, enter -0-.	**(e)** Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	**(f)** Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	**(g)** Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	**(h)** Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
MASSACHUSETTS MUTUAL LIFE INS. CO.	72	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
PREM SHORT-DURATION BOND BABSON 04-3212057	BASIS POINTS * PLAN ASSETS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
MASSACHUSETTS MUTUAL LIFE INS. CO.	72	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
PREMIER CORE BOND BABSON 04-3277549	BASIS POINTS * PLAN ASSETS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
MASSACHUSETTS MUTUAL LIFE INSURANCE	72	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
SEL BLUE CHIP GR II T.ROWE PRICE 04-3556992	BASIS POINTS * PLAN ASSETS

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
MASSACHUSETTS MUTUAL LIFE INS. CO.	72	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
SEL SMCOVAL FED CLOV/TRP/ERNST 04-3584140	BASIS POINTS * PLAN ASSETS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
MASSACHUSETTS MUTUAL LIFE INS. CO.	72	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
SELECT FUNDAMENTAL VAL WELLINGTON 04-3584138	BASIS POINTS * PLAN ASSETS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
MASSACHUSETTS MUTUAL LIFE INS. CO.	72	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
SELECT OVERSEARS MFS/HARRIS/ALLBER 04-3557000	BASIS POINTS * PLAN ASSETS

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
MASSACHUSETTS MUTUAL LIFE INS. CO.	72	0
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
SELECT SM CAP GR W&R/WELLINGTON 04-3464205	BASIS POINTS * PLAN ASSETS	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

Part III **Termination Information on Accountants and Enrolled Actuaries (see instructions)**
(complete as many entries as needed)

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN;
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN;
c	Position:	
d	Address:	**e** Telephone:

Explanation:

SCHEDULE D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2010

This Form is Open to Public Inspection.

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A Name of plan
PENSION PLAN FOR SALARIED EMPLOYEES OF METAL TECHNOLOGY SOLUTIONS, INC.

B Three-digit plan number (PN) ▶ 002

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
METAL TECHNOLOGY SOLUTIONS, INC.

D Employer Identification Number (EIN)
52-2337203

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)

(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AY			
b Name of sponsor of entity listed in (a): MMLIC			
c EIN-PN 04-1590850-177	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	848516
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AL			
b Name of sponsor of entity listed in (a): MMLIC			
c EIN-PN 04-1590850-019	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	1172151
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AK			
b Name of sponsor of entity listed in (a): MMLIC			
c EIN-PN 04-1590850-175	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	1130582
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AH			
b Name of sponsor of entity listed in (a): MMLIC			
c EIN-PN 04-1590850-155	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	320342
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AG			
b Name of sponsor of entity listed in (a): MMLIC			
c EIN-PN 04-1590850-016	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	115174
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AF			
b Name of sponsor of entity listed in (a): MMLIC			
c EIN-PN 04-1590850-015	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	531408
a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AE			
b Name of sponsor of entity listed in (a): MMLIC			
c EIN-PN 04-1590850-014	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)	1062744

a Name of MTIA, CCT, PSA, or 103-12 IE: SIA-AC

b Name of sponsor of entity listed in (a): MMLIC

c EIN-PN 04-1590850-012	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 851616

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II Information on Participating Plans (to be completed by DFEs)

(Complete as many entries as needed to report all participating plans)

a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN

SCHEDULE I (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information—Small Plan

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2010

This Form is Open to Public Inspection

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A Name of plan
PENSION PLAN FOR SALARIED EMPLOYEES OF METAL TECHNOLOGY SOLUTIONS, INC.

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
METAL TECHNOLOGY SOLUTIONS, INC.

D Employer Identification Number (EIN)
52-2337203

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. **Round off amounts to the nearest dollar.**

			(a) Beginning of Year	**(b)** End of Year
1	**Plan Assets and Liabilities:**			
a	Total plan assets	**1a**	5601778	6125812
b	Total plan liabilities	**1b**		
c	Net plan assets (subtract line 1b from line 1a)	**1c**	5601778	6125812
2	**Income, Expenses, and Transfers for this Plan Year:**		**(a)** Amount	**(b)** Total
a	Contributions received or receivable:			
	(1) Employers	**2a(1)**	118427	
	(2) Participants	**2a(2)**		
	(3) Others (including rollovers)	**2a(3)**		
b	Noncash contributions	**2b**		
c	Other income	**2c**	755363	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	**2d**		873790
e	Benefits paid (including direct rollovers)	**2e**	349756	
f	Corrective distributions (see instructions)	**2f**		
g	Certain deemed distributions of participant loans (see instructions)	**2g**		
h	Administrative service providers (salaries, fees, and commissions)	**2h**		
i	Other expenses	**2i**		
j	Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	**2j**		349756
k	Net income (loss) (subtract line 2j from line 2d)	**2k**		524034
l	Transfers to (from) the plan (see instructions)	**2l**		

3 **Specific Assets:** If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

			Yes	**No**	**Amount**
a	Partnership/joint venture interests	**3a**		X	
b	Employer real property	**3b**		X	
c	Real estate (other than employer real property)	**3c**		X	
d	Employer securities	**3d**		X	
e	Participant loans	**3e**		X	

			Yes	No	Amount
3f	Loans (other than to participants)	3f		X	
g	Tangible personal property	3g		X	

Part II Compliance Questions

4 During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
e Was the plan covered by a fidelity bond?	4e	X		50000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X	
k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If "Yes," enter the amount of any plan assets that reverted to the employer this year ☐ **Yes** ☒ **No** **Amount:**

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2010

This Form is Open to Public Inspection.

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

A Name of plan
PENSION PLAN FOR SALARIED EMPLOYEES OF METAL TECHNOLOGY SOLUTIONS, INC.

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
METAL TECHNOLOGY SOLUTIONS, INC.

D Employer Identification Number (EIN)
52-2337203

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions **1** 0

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):

EIN(s): 04-1590850

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year. **3** 0

Part II Funding Information (If the plan is not subject to the minimum funding requirements of section of 412 of the Internal Revenue Code or ERISA section 302, skip this Part)

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? ..... ☐ **Yes** ☐ **No** ☒ **N/A**

If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____

If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 **a** Enter the minimum required contribution for this plan year **6a**

b Enter the amount contributed by the employer to the plan for this plan year **6b**

c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) **6c**

If you completed line 6c, skip lines 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline? ..... ☐ **Yes** ☐ **No** ☐ **N/A**

8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? ..... ☒ **Yes** ☐ **No** ☐ **N/A**

Part III Amendments

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box(es). If no, check the "No" box. ..... ☐ **Increase** ☐ **Decrease** ☐ **Both** ☒ **No**

Part IV ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? ..... ☐ **Yes** ☐ **No**

11 **a** Does the ESOP hold any preferred stock? ..... ☐ **Yes** ☐ **No**

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) ..... ☐ **Yes** ☐ **No**

12 Does the ESOP hold any stock that is not readily tradable on an established securities market? ..... ☐ **Yes** ☐ **No**

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

14 Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:

a The current year	**14a**	
b The plan year immediately preceding the current plan year	**14b**	
c The second preceding plan year	**14c**	

15 Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

a The corresponding number for the plan year immediately preceding the current plan year	**15a**	
b The corresponding number for the second preceding plan year	**15b**	

16 Information with respect to any employers who withdrew from the plan during the preceding plan year:

a Enter the number of employers who withdrew during the preceding plan year	**16a**	
b If item 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	**16b**	

17 If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment. ☐

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

18 If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment ☐

19 If the total number of participants is 1,000 or more, complete items (a) through (c)

a Enter the percentage of plan assets held as:
Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%

b Provide the average duration of the combined investment-grade and high-yield debt:
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

c What duration measure was used to calculate item 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify):

Pension Plan for Salaried Employees of Metal Technology Solutions, Inc.
EIN/PN: 52-2337203 / 002

Schedule SB, Part V – Statement of Actuarial Assumptions/Methods

Prescribed Funding Assumptions and Methods

Funding

Current Year:	First Segment Rate	5.03%
	Second Segment Rate	6.73%
	Third Segment Rate	6.82%
	Effective Interest Rate	6.70%
Prior Year:	Effective Interest Rate - using the full yield curve for the preceding month of October	8.19%

Investment & administrative expenses

None assumed to be paid from plan assets.

Mortality

The IRS 2010 Annuitant and Non-Annuitant Mortality Tables for Males and Females.

Non-Prescribed Funding Assumptions and Methods

Withdrawal rates

Age	Male Assumption	Female Assumption
25	5.00%	7.15%
30	3.90%	5.00%
35	3.20%	3.90%
40	2.65%	3.20%
45	1.80%	2.65%
50	0.80%	1.80%
55	0.30%	0.80%
60	0.10%	0.30%
61	0.08%	0.24%
62	0.06%	0.18%
63	0.04%	0.12%
64	0.02%	0.06%

Retirement Rates

100% assumed at age 65.

Disability rates

1985 Disability Table for Class I Employees. Sample rates shown below:

Age	Male Assumption	Female Assumption
25	0.038%	0.047%
35	0.069%	0.136%
45	0.202%	0.323%
55	0.722%	0.952%

Marital percentage

80% of participants are assumed to be married at death, with husband 3 years older than wife.

Valuation of optional payment forms

50% of participants are assumed to elect a single life annuity and 50% are assumed to elect a 50% Joint and Survivor annuity.

Non-Prescribed Funding Assumptions and Methods (continued)

Actuarial cost method

For minimum required and maximum contribution purposes:
The Funding Target is the present value of accrued benefits (frozen as of December 31, 2007) and based on service to date. The Target Normal Cost is the present value of benefits expected to be accrued during the current plan year. The Target Normal Cost is equal to 0 since the plan was frozen as of December 31, 2007.

Asset valuation method

For minimum required and maximum contribution purposes: Smoothed Asset Value over 2 year period. The Valuation Assets are determined using a method that spreads asset gains/(losses) over 2 years. The gain/(loss) for each period is determined as the actual return during the period less the expected return based on an assumed earnings rate chosen by the actuary but required by PPA to be not greater than the applicable third segment rate. The resulting value is constrained to be within a corridor of 90% to 110% of market value. Accrued contributions, if any, are included in the Valuation Assets.
The expected return on plan assets is 8.00% per annum, limited by PPA to the applicable Third Segment Rate as follows:

2009 measurement period:	6.69%
2008 measurement period:	6.43%

Pension Plan for Salaried Employees of Metal Technology Solutions, Inc.
EIN/PN: 52-2337203 / 002

Schedule SB, Part V – Summary of Plan Provisions

Eligibility:	Age 21 and one year, and hired prior to December 31, 2006.
Annual compensation:	Base pay plus shift differential and overtime, excludes bonuses.
Average compensation:	Annual compensation of the 5 consecutive years out of the last 10 that produces the highest average. Annual compensation is not to exceed required limits. This amount was frozen as of December 31, 2006.
Payment form:	Life annuity.
Normal retirement date:	Age 65 with 5 years of participation.
Early retirement date:	Age 55 and 15 years of service or age 62.
Eligibility for disability benefit:	Disability occurring while actively employed with 5 years of service.
Eligibility for vested benefit:	100% vesting after five years.
Eligibility for surviving spouse death benefit:	Death occurring while: 1. Actively employed, completed 5 years of vesting service. 2. Terminated with a vested deferred benefit but before benefit commencement.
Accrued benefit:	The benefit determined under (A plus B) multiplied by C below. The accrued benefit was frozen as of December 31, 2006. A. 50% of average compensation at date of termination, less 50% of primary Social Security amount at age 65, reduced by 1/25 for each year of service less than 25 at normal retirement date. B. 1% of A. for each year of service at normal retirement over 25 years, to a maximum of 10% of A. C. For termination prior to normal retirement date, ratio of service at termination to service at normal retirement.

Pension Plan for Salaried Employees of Metal Technology Solutions, Inc.
EIN/PN: 52-2337203 / 002

Schedule SB, Part V – Summary of Plan Provisions

Normal monthly retirement benefit:	One-twelfth of accrued benefit as of normal retirement date.
Early monthly retirement benefit:	One-twelfth of accrued benefit as of early retirement date, reduced by 3.6% for each year by which the early retirement date precedes the normal retirement date.
Delayed monthly retirement benefit:	One-twelfth of accrued benefit as of actual retirement date, crediting service and earnings through delayed retirement date.
Disability retirement benefit:	One-twelfth of accrued benefit payable at normal retirement date, assuming service and compensation at date of disability continues until normal retirement date.
Deferred monthly retirement benefit for termination prior to retirement:	One-twelfth of accrued benefit as of date of termination, payable at normal retirement date. Benefits may be taken as early as age 62 (or as early as age 55 if more than 15 years of service at termination), but will be reduced by 3.6% for each year by which the benefit commencement date precedes the normal retirement date.
Surviving spouse monthly death benefit:	One-twelfth of 50% of accrued benefit reduced for early payment in the form of a 50% Joint and Survivor as of date of death of participant, commencing at the participant's earliest payment date and continuing for the remaining lifetime of the surviving spouse.
Optional forms of payment	Life annuity for married participants. 50%, 66 $^{2}/_{3}$%, 75% and 100% joint and survivor annuity 10 year certain and continuous annuity
Actuarial Equivalent	A benefit of equivalent value to the benefit it replaces calculated on the basis of 8.75% interest and use of TPF&C 1971 Forecast Table set back 6 years as the age of the spouse in any case where joint and survivor benefits are paid to a member and his spouse.

Summary of Changes from the January 1, 2009 Valuation

None.

Pension Plan for Salaried Employees of Metal Technology Solutions, Inc.
EIN/PN: 52-2337203 / 002

Schedule SB, line 25- Change in Method

- The interest rates used to value plan liabilities have been changed to use the three-tiered segment rates with a four-month look-back, which results in an effective interest rate of 6.70% for the 2010 valuation. For the prior year the full yield curve with a two-month look-back was used and resulted in an effective rate of 8.19%.

Pension Plan for Salaried Employees of Metal Technology Solutions, Inc.
EIN/PN: 52-2337203 / 002

Schedule SB, line 32- Schedule of Amortization Bases

Date Established	Initial Amount	Remaining Installments[1]	Shortfall Amortization Installment	Present Value of Remaining Installments as of January 1, 2010
January 1, 2008	$ 0	5	$ 0	$ 0
January 1, 2009	188,975	6	33,533	176,569
January 1, 2010	1,113,614	9	74,612	1,113,614
Total charge			$ 108,145	$ 1,290,183

[1] An election has been made under PRA 2010 to use the alternative 2 plus 7-year amortization period for the base established in 2010. Under 2 plus 7-year amortization, the required installments for the first 2 years of the amortization period equal interest on the base at the plan's effective interest rate for the plan year of the election. The balance is then amortized over the following 7 years in level installments determined using the discount rates for the plan year of the election.

Pension Plan for Salaried Employees of Metal Technology Solutions, Inc.
EIN/PN: 52-2337203 / 002

Schedule SB, Line 26 - Schedule of Active Participant Data

Age	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40+	Total
15-19	0	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	0	0	0	0	0	0
25-29	0	0	0	0	0	0	0	0	0	0	0
30-34	0	1	2	2	1	0	0	0	0	0	6
35-39	0	1	1	3	0	0	0	0	0	0	5
40-44	0	0	0	1	2	1	0	0	0	0	4
45-49	0	0	2	0	2	0	0	0	0	0	4
50-54	0	0	1	0	1	2	0	2	2	0	8
55-59	0	0	1	0	0	0	0	2	3	0	6
60-64	0	0	2	0	0	0	0	1	3	0	6
65-69	0	0	0	0	0	0	0	0	0	0	0
70+	0	0	0	0	0	0	0	0	0	0	0
TOTAL	0	2	9	6	6	3	0	5	8	0	39

Pension Plan for Salaried Employees of Metal Technology Solutions, Inc.
EIN/PN: 52-2337203 / 002

Schedule SB, Line 22 - Description of Weighted Average Retirement Age

The expected retirement age is 65 for all active and terminated vested participants.

SCHEDULE SB (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Single-Employer Defined Benefit Plan Actuarial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500 or 5500-SF.

OMB No. 1210-0110

2010

This Form is Open to Public Inspection

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of $1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan

Pension Plan for Salaried Employees of Metal Technology Solutions,

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF

Metal Technology Solutions, Inc

D Employer Identification Number (EIN)

52-2337203

E Type of plan: [X] Single [ ] Multiple-A [ ] Multiple-B

F Prior year plan size: [ ] 100 or fewer [X] 101-500 [ ] More than 500

Part I Basic Information

1 Enter the valuation date: Month 1 Day 1 Year 2010

2	Assets:			
	a Market value		**2a**	5,599,710
	b Actuarial value		**2b**	5,685,173
3	Funding target/participant count breakdown		(1) Number of participants	(2) Funding Target
	a For retired participants and beneficiaries receiving payment	**3a**	24	3,454,598
	b For terminated vested participants	**3b**	34	1,480,126
	c For active participants:			
	(1) Non-vested benefits	**3c(1)**		9,921
	(2) Vested benefits	**3c(2)**		2,321,351
	(3) Total active	**3c(3)**	39	2,331,272
	d Total	**3d**	97	7,265,996
4	If the plan is at-risk, check the box and complete items (a) and (b) [ ]			
	a Funding target disregarding prescribed at-risk assumptions		**4a**	
	b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor		**4b**	
5	Effective interest rate		**5**	6.70 %
6	Target normal cost		**6**	0

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE

Kelly R Swart — Signature of actuary

10/6/2011 — Date

Kelly R. Swart — Type or print name of actuary

11-05429 — Most recent enrollment number

Buck Consultants, LLC — Firm name

(412)281-2506 — Telephone number (including area code)

500 Grant Street, Suite 2900

Pittsburgh PA 15219-2513 — Address of the firm

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions [ ]

Part II Beginning of year carryover and prefunding balances

		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (Item 13 from prior year)	0	0
8	Portion used to offset prior year's funding requirement (Item 35 from prior year)	0	0
9	Amount remaining (item 7 minus item 8)	0	0
10	Interest on item 9 using prior year's actual return of 25.76%		
11	Prior year's excess contributions to be added to prefunding balance:		
	a Excess contributions (Item 38 from prior year)		0
	b Interest on (a) using prior year's effective rate of 8.19%		0
	c Total available at beginning of current plan year to add to prefunding balance		0
	d Portion of (c) to be added to prefunding balance		0
12	Reduction in balances due to elections or deemed elections	0	0
13	Balance at beginning of current year (item 9 + item 10 + item 11d - item 12)	0	0

Part III Funding percentages

14	Funding target attainment percentage	14	78.24 %
15	Adjusted funding target attainment percentage	15	78.24 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	90.65 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and liquidity shortfalls

18 Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
04/15/2010	8,383				
07/15/2010	8,383				
10/15/2010	8,383				
01/14/2011	8,383				
09/15/2011	84,895				
			Totals ► 18(b)	118,427	18(c) 0

19 Discounted employer contributions - see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contribution from prior years.	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	108,145

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? [X] Yes [ ] No

b If 20a is "Yes," were required quarterly installments for the current year made in a timely manner? [X] Yes [ ] No

c If 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of Quarter of this plan year

(1) 1st	(2) 2nd	(3) 3rd	(4) 4th
0	0	0	0

Part V Assumptions used to determine funding target and target normal cost

21 Discount rate:

a Segment rates:

1st segment:	2nd segment:	3rd segment:	
5.03 %	6.73 %	6.82 %	☐ N/A, full yield curve used

b Applicable month (enter code) — **21b**: 4

22 Weighted average retirement age — **22**: 65

23 Mortality table(s) (see instructions) ☐ Prescribed - combined ☒ Prescribed - separate ☐ Substitute

Part VI Miscellaneous items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. ☐ Yes ☒ No

25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. ☒ Yes ☐ No

26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. ☒ Yes ☐ No

27 If the plan is eligible for (and is using) alternative funding rules, enter applicable code and see instructions regarding attachment — **27**:

Part VII Reconciliation of unpaid minimum required contributions for prior years

28 Unpaid minimum required contribution for all prior years	**28**	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (item 19a)	**29**	0
30 Remaining amount of unpaid minimum required contributions (item 28 minus item 29)	**30**	0

Part VIII Minimum required contribution for current year

31 Target normal cost, adjusted, if applicable (see instructions)		**31**	0
32 Amortization installments:	Outstanding Balance		Installment
a Net shortfall amortization installment	1,290,183		108,145
b Waiver amortization installment	0		0
33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount		**33**	
34 Total funding requirement before reflecting carryover/prefunding balances (item 31 + item 32a + item 32b - item 33)		**34**	108,145
	Carryover balance	Prefunding balance	Total balance
35 Balances used to offset funding requirement	0	0	0
36 Additional cash requirement (item 34 minus item 35)		**36**	108,145
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (item 19c)		**37**	108,145
38 Interest-adjusted excess contributions for current year (see instructions)		**38**	0
39 Unpaid minimum required contribution for current year (excess, if any, of item 36 over item 37)		**39**	0
40 Unpaid minimum required contribution for all years		**40**	0

Form **5558**
(Rev. June 2011)
Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File Certain Employee Plan Returns

► **For Privacy Act and Paperwork Reduction Act Notice, see instructions.**

OMB No. 1545-0212

File With IRS Only

Part I Identification

A Name of filer, plan administrator, or plan sponsor (see instructions)

Number, street, and room or suite no. (If a P.O. box, see instructions)

City or town, state, and ZIP code

B **Filer's identifying number (see instructions)**

Employer identification number (EIN)

Social security number (SSN) (see instructions)

C	**Plan name**	**Plan number**	**Plan year ending—**		
			MM	**DD**	**YYYY**
1					
2					
3					

Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA

1 I request an extension of time until ____/____/____ to file Form 5500 series (see instructions).
Note. A signature IS NOT required if you are requesting an extension to file Form 5500 series.

2 I request an extension of time until ____/____/____ to file Form 8955-SSA (see instructions).
Note. A signature IS required if you are requesting an extension to file Form 8955-SSA.

The application **is automatically approved** to the date shown on line 1 and/or line 2 (above) if: **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and **(b)** the date on line 1 and/or line 2 (above) is not later than the 15th day of the third month after the normal due date.

Part III Extension of Time To File Form 5330 *(see instructions)*

3 I request an extension of time until ____/____/____ to file Form 5330.
You may be approved for up to a 6 month extension to file Form 5330, after the normal due date of Form 5330.

a Enter the Code section(s) imposing the tax . . . . . ► **a**

b Enter the payment amount attached . . . . . ► **b**

c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date . . . ► **c**

4 **State in detail why you need the extension:**

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ► **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

Use Form 5558 to apply for a one-time extension of time to file the Form 5500 series (Form 5500, Annual Return/Report of Employee Benefit Plan; Form 5500-SF, Short Form Annual Return/Report of Small Employee Benefit Plan; Form 5500-EZ, Annual Return of One-Participant (Owners and Their Spouses) Retirement Plan); Form 8955-SSA, Annual Registration Statement Identifying Separated Participants With Deferred Vested Benefits; or Form 5330, Return of Excise Taxes Related to Employee Benefit Plans.

An extension of time to file does not extend the time to pay the tax due. Any tax due must be paid with this application for an extension of time to file Form 5330. Additionally, interest is charged on taxes not paid by the due date even if an extension of time to file is granted.

Where To File

File Form 5558 with the Department of the Treasury, Internal Revenue Service Center, Ogden, UT 84201-0045.

Private delivery services. You can use certain private delivery services designated by the IRS to meet the "timely mailing treated as timely filing/paying" rule for tax returns and payments. If you use a private delivery service designated by the IRS (rather than the U.S. Postal Service) to send your return, the postmark date generally is the date the private delivery service records in its database or marks on the mailing label. The private delivery service can tell you how to get written proof of this date.

The following are designated private delivery services:

• DHL Express (DHL): DHL Same Day Service.

• Federal Express (FedEx): FedEx Priority Overnight, FedEx Standard Overnight, FedEx 2 Day, FedEx International Priority, and FedEx International First.

• United Parcel Service (UPS): UPS Next Day Air, UPS Next Day Air Saver, UPS 2nd Day Air, UPS 2nd Day Air A.M., UPS Worldwide Express Plus, and UPS Worldwide Express.

Private delivery services cannot deliver items to P.O. boxes. You must use the U.S. Postal Service to mail any item to an IRS P.O. box address.

Specific Instructions

Part I. Identification

A. Name and Address

Enter your name and address in the heading if you are requesting an extension of time to file the Form 5500, Form 5500-SF, Form 5500-EZ and/or Form 8955-SSA or Form 5330.

The sponsor (generally, the employer for a single-employer plan) or plan administrator listed on the application should be the same as the plan sponsor or plan administrator listed on the annual return/report filed for the plan.

Include the suite, room, or other unit number after the street address. If the Post Office does not deliver mail to the street address and you have a P.O. box, show the box number instead of the street address.

If the entity's address is outside the United States or its possessions, or territories, enter in the space for city or town, state, and ZIP code, the information in the following order: city, province or state, and country. Follow the country's practice for entering the postal code. Do not abbreviate the country name.

If your mailing address has changed since you filed your last return, use Form 8822, Change of Address, to notify the IRS of the change. A new address shown on Form 5558 will not update your record.

B. Filer's Identifying Number

Employer identification number (EIN). Enter the nine-digit EIN assigned to the employer for all applications filed for the Form 5500 series (Form 5500, Form 5500-SF, Form 5500-EZ) and/or Form 8955-SSA. Also enter the EIN for applications filed for Form 5330 (see *Social security number (SSN)* next for exceptions).

If the employer does not have an EIN, the employer must apply for one. An EIN can be applied for:

• Online by clicking the Online EIN Application link at IRS.gov. The EIN is issued immediately once the application information is validated.

• By telephone at 1-800-829-4933.

• By fax using the FAX-TIN numbers for your state listed in the Instructions for Form SS-4.

• Employers who do not have an EIN may apply for one by attaching a completed Form SS-4, Application for Employer Identification Number, to this form.

The online application process is not yet available for corporations with addresses in foreign countries.

Social security number (SSN). If you made excess contributions to a section 403(b)(7)(A) custodial account or you are a disqualified person other than an employer, and you are applying for an extension of time to file Form 5330, enter your SSN. Do not enter your SSN for Form 5500, Form 5500-SF, Form 5500-EZ, or Form 8955-SSA.

C. Plan Information

Complete the entire table (plan name, plan number, and plan year ending) for all plans included on this Form 5558.

Part II. Extension of Time To File Form 5500 Series and/or Form 8955-SSA

Use Form 5558 to apply for a one-time extension of time to file the Form 5500 series (Form 5500, Form 5500-SF, Form 5500-EZ) and/or Form 8955-SSA. Do not use Form 5558 to extend the due date of Form 8955-SSA for the 2009 and 2010 plan years if the 2010 plan year ends before April 1, 2011. Such returns already have an extended due date until January 17, 2012.

Do not include the Form 5500 series (Form 5500, Form 5500-SF, Form 5500-EZ) or the Form 8955-SSA with this form.

Exception: Form 5500, Form 5500-SF, Form 5500-EZ, and Form 8955-SSA filers are automatically granted extensions of time to file until the extended due date of the federal income tax return of the employer (and are not required to file Form 5558) if both of the following conditions are met: (1) the plan year and the employer's tax year are the same; and (2) the employer has been granted an extension of time to file its federal income tax return to a date later than the normal due date for filing the Form 5500, Form 5500-SF, Form 5500-EZ, or Form 8955-SSA. An extension granted under this exception cannot be extended further by filing a Form 5558 after the normal due date of the Form 5500, Form 5500-SF, Form 5500-EZ, or Form 8955-SSA.

An extension of time to file a Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA does not operate as an extension of time to file the PBGC Form 1.

How to file. In general, a separate Form 5558 is used for each return for which you are requesting an extension. However, if the employer maintains more than one single employer plan and the plan years end on the same date, you may file a single Form 5558 to apply for extensions to file Forms 5500, Forms 5500-SF, Forms 5500-EZ, and/or Forms 8955-SSA for up to three of these plans. For example, if the employer maintains a defined benefit plan, a money purchase plan, and a profit-sharing plan (all of which are single employer plans), you may apply for extensions to file Form 5500 and Form 8955-SSA for all of these plans by filing a single Form 5558.

When to file. To request an extension of time to file Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA, file Form 5558 on or before the return/report's normal due date. The normal due date is the date the Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA would otherwise be due, without extension.

Applications for extension of time to file Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA that are filed on or before the return/report's normal due date on a properly completed Form 5558 will be automatically approved to the date that is no later than the 15th day of the third month after the return/report's normal due date.

Note. If the filing date falls on a Saturday, Sunday, or a legal holiday, the return may be filed on the next day that is not a Saturday, Sunday, or a legal holiday.

Approved copies of Form 5558 requesting an extension to file Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA will not be returned to the filer from the IRS.

Line 1. Enter on line 1 the due date for which you are requesting to file Form 5500, Form 5500-SF, or Form 5500-EZ. This date should not be later than the 15th day of the third month after the normal due date of the return/report.

When using Form 5558 to request an extension of time to file Form 5500, Form 5500-SF, or Form 5500-EZ, plan sponsors or plan administrators are not required to sign the form. If Form 5558 is timely filed and complete, you will be granted an extension not later than the 15th day of the third month after the return/report's normal due date to file Form 5500, Form 5500-SF, or Form 5500-EZ.

Line 2. Enter on line 2 the due date for which you are requesting to file Form 8955-SSA. This date should not be later than the 15th day of the third month after the normal due date of the return.

When using Form 5558 to request an extension of time to file Form 8955-SSA, plan sponsors or plan administrators are required to sign the form. If Form 5558 is timely filed and complete, you will be granted an extension not later than the 15th day of the third month after the return's normal due date to file Form 8955-SSA.

If you are filing separate Forms 8955-SSA for the 2009 and 2010 plan years, you may use a single Form 5558 to extend the filing date for both years. In that case, enter the plan year ending date for the 2010 plan year in Part I. The filing date for the 2009 and 2010 Forms 8955-SSA will be extended to the date entered on line 2.

Part III. Extension of Time To File Form 5330

File one Form 5558 to request an extension of time to file Form 5330 for excise taxes with the same filing due date. For specific information on excise tax due dates, see the Instructions for Form 5330.

Note. The IRS will no longer return stamped copies of the Form 5558 to filers who request an extension of time to file a Form 5330. Instead you will receive a computer generated notice to inform you if your extension is approved or denied. Because of this change, we ask you to attach a photocopy of this notice to your Form 5330.

When to file. To request an extension of time to file Form 5330, file Form 5558 in sufficient time for the IRS to consider and act on it before the return's normal due date.

The normal due date is the date the Form 5330 would otherwise be due, without extension.

Line 3. On line 3, enter the requested due date. If your application for extension of time to file Form 5330 is approved, you may be granted an extension of up to 6 months after the normal due date of Form 5330.

Line 3a. Indicate the section(s) for the excise tax for which you are requesting an extension.

Line 3b. Enter the amount of tax estimated to be due with Form 5330 and attach your payment to this form.

Make your check or money order payable to the "United States Treasury." Do not send cash. On all checks or money orders, write your name, filer's identifying number (EIN or SSN), plan number, Form 5330 section number, and the tax year to which the payment applies.

If you changed your mailing address after you filed your last return, use Form 8822 to notify the IRS of the change. You can get Form 8822 by calling 1-800-829-3676 or you can access the IRS website at IRS.gov 24 hours a day, 7 days a week.

Line 4. The IRS will grant a reasonable extension of time (not to exceed 6 months) for filing Form 5330 if you file a timely application showing that you are unable to file Form 5330 because of circumstances beyond your control. Clearly describe these circumstances. Generally, an application will be considered on the basis of your own efforts to fulfill this filing responsibility, rather than the convenience of anyone providing help in preparing the return. However, consideration will be given to any circumstances that prevent your practitioner, for reasons beyond his or her control, from filing the return by the normal due date, and to circumstances in which you are unable to get needed professional help in spite of timely efforts to do so.

If we grant you an extension of time to file Form 5330 and later find that the statements made on this form are false or misleading, the extension will be null and void. A late filing penalty associated with the form for which you filed this extension will be charged.

Signature

If you are filing Form 5558 for an extension to file Form 5330 and/or Form 8955-SSA, the form must be signed. The person who signs this form may be a plan administrator, employer, plan sponsor, or any other individual or authorized representative required to sign the Form 5330 and/or Form 8955-SSA.

Privacy Act and Paperwork Reduction Act Notice

We ask for the information on this form to carry out the Internal Revenue laws of the United States and the Employee Retirement Income Security Act of 1974 (ERISA). We need it to determine if you are entitled to an extension of time to file Form 5500, Form 5500-SF, Form 5500-EZ, and/or Form 8955-SSA, or Form 5330. If you want an extension, section 6081 requires you to provide the information. Section 6109 requires you to provide your taxpayer identification number (SSN or EIN). Failure to provide this information may delay or prevent processing your request; providing false information may subject you to penalties.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential as required by section 6103.

However, section 6103 allows or requires the Internal Revenue Service to disclose this information to others. We may disclose to the Department of Justice for civil or criminal litigation, to the Department of Labor and the Pension Benefit Guaranty Corporation for the administration of ERISA, and to cities, states, the District of Columbia, and U.S. commonwealths or possessions to carry out their tax laws. We may also disclose the information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time: 24 minutes.

If you have comments concerning the accuracy of this time estimate or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave., NW, IR-6526, Washington, DC 20224. Do not send the tax form to this address. Instead, see *Where To File*.