



## VEBA/115 Trust & 401(h) Installation Kit



## VEBA/115 Trust Plan & 401(h)

Congratulations! You have a plan that will be converting to the **VEBA/115 Trust & 401(h)** program offered by BPAS. We look forward to working with you to ensure a smooth conversion process and improving the overall level of service experienced by your plan. This kit is the first critical step.

A conversion is a collaborative process. This **Installation Kit** contains all the forms you'll need to get your plan established. You'll be working with our team of experts, who will be right there guiding you through each step and streamlining this process for your organization while setting the stage for a successful administrative relationship moving forward.



## Let's get started.

### FORMS & EXHIBITS

#### REQUIRED

**REQUIRED:** Please complete and submit the following forms and exhibits together as soon as possible so that our conversion team can proceed with your plan setup without delays.

- ☐ Signed Fee Schedule
- ☐ BPAS Installation Kit\*
- ☐ Current W-9
- ☐ Current Adoption Agreement (if applicable)
- ☐ Current Pension Plan Recordkeeper (401(h) only)

**\*IMPORTANT NOTE:** This PDF document is prepared as an interactive form. Please complete it electronically.

#### OPTIONAL

**OPTIONAL:** The following exhibits and forms are required but may follow at a later date.

- ☐ Plan Sponsor ACH Authorization Form (see [Appendices](#))
- ☐ Completed W-9, OR copy of IRS letter assigning your Employer Identification Number, OR Articles of Incorporation, OR Form SS-4 Application
- ☐ Census data to BPAS (see [Appendices](#))

*Where applicable please provide the following supporting documentation.*

- |   |   |
|---|---|
| <input type="checkbox"/> Any Plan Amendments      | <input type="checkbox"/> Summary of Material Modification |
| <input type="checkbox"/> Basic Plan Document      | <input type="checkbox"/> Private Letter Ruling (PLR)      |
| <input type="checkbox"/> Summary Plan Description |   |
| <input type="checkbox"/> Most Recent Valuation    |   |

# VEBA/115 Trust Plan & 401(h)

Please fill in all the information as accurately as possible. The information you provide will assist in building your complete Health Trust plan profile. This PDF document is prepared as an interactive form. Please complete it electronically.

Please note that 401(h) features must be incorporated in Pension Plan document.

**BPAS Service Requested (check one):** ☐ Recordkeeping ☐ Full Administration

## EMPLOYER/PLAN SPONSOR INFORMATION

Employer/Plan Sponsor Name:

Mailing Address:

City:	State:	Zip:	Number of eligible employees:
Phone:	Fax:	Web Address:	
EIN:	Fiscal Year End:	Governed by (State law):	

Primary Contact Full Name & Title:

Phone: Email Address:

Entity Type (public sector): ☐ Bargaining Units ☐ Labor Sponsor Trust ☐ Multi-employer Trust ☐ Governmental Group  
☐ Municipality ☐ Church Group

## TRUST INFORMATION

Name of Trust:

Trust Type: ☐ VEBA 501(c)(9) Trust ID#: (Attach: Executed Trust, Determination Letter, IRS TIN Letter) ☐ 115 Trust (Attach: Executed Trust) ☐ Pension Plan Trust with 401(h)

Current Assets:	Number of Participants:	Effective Date for BPAS Trust:
Form 990 will be prepared by:	<input type="radio"/> BPAS <input type="radio"/> Other:	<input type="radio"/> N/A (per attached determination letter)
State form will be prepared by:	<input type="radio"/> BPAS <input type="radio"/> Other:	<input type="radio"/> N/A (per attached determination letter)
Form 5500 will be prepared by:	<input type="radio"/> BPAS <input type="radio"/> Other:	<input type="radio"/> N/A (per attached determination letter)
Documents will be created by:	<input type="radio"/> BPAS <input type="radio"/> Other:	<input type="radio"/> N/A (per attached determination letter)

Hand Benefits & Trust, a BPAS company, will serve as:

☐ Directed Trustee ☐ Custodian. Trustee is:

Investments/ Funds: ☐ Open Architecture ☐ BPAS Fiduciary Directed: Institutional

## PLAN INFORMATION

Plan-year End Date: ☐ Start-Up ☐ Existing

Official Plan Name:

Important Dates:	Current Effective Date:
	BPAS Restatement Date:
	BPAS Service Effective Date:
	Claims Eligible Date:

Is this plan subject to ERISA? ☐ Yes ☐ No

Are there non-represented employees that participate in the plan? ☐ Yes ☐ No

Is this a spend-down only? ☐ Yes ☐ No

Is this plan grandfathered for designated beneficiary? ☐ Yes ☐ No

Claims Reimbursement: ☐ Active and Terminated Employees ☐ Terminated Employees Only

Plan Sponsor	Contact Information 1: Main Contact	Contact Information 2
Full Name		
Title		
Company Name		
Physical Address	<input type="radio"/> Same as corporate address	<input type="radio"/> Same as corporate address
	Address 1:	Address 1:
	Address 2:	Address 2:
	City:	City:
	State:	State:
	Zip:	Zip:
Email Address		
Contact Number	Phone:	Phone:
	Fax:	Fax:
Contact Type (check all that apply)	<input type="radio"/> Principal/Owner	<input type="radio"/> Principal/Owner
	<input type="radio"/> Payroll	<input type="radio"/> Human Resources
	<input type="radio"/> Plan Document	<input type="radio"/> Census
	<input type="radio"/> Required Notices	<input type="radio"/> Billing
	<input type="radio"/> Plan Portal Access	<input type="radio"/> Email Alerts
	<input type="radio"/> Authorized Signer	<input type="radio"/> Authorized Signer
FI/Advisor	Contact Information 1: Main Contact	Contact Information 2
Full Name		
Title		
Company Name		
Physical Address	Address 1:	Address 1:
	Address 2:	Address 2:
	City:	City:
	State:	State:
	Zip:	Zip:
Email Address		
Contact Number	Phone:	Phone:
	Fax:	Fax:
Contact Type (check all that apply)	<input type="radio"/> Plan Document	<input type="radio"/> Plan Document
	<input type="radio"/> Required Notices	<input type="radio"/> Billing
	<input type="radio"/> Plan Portal Access	<input type="radio"/> Email Alerts
Broker	Contact Information 1: Main Contact	Contact Information 2
Full Name		
Title		
Company Name		
Physical Address	Address 1:	Address 1:
	Address 2:	Address 2:
	City:	City:
	State:	State:
	Zip:	Zip:
Email Address		
Contact Number	Phone:	Fax:
Contact Type (check all that apply)	<input type="radio"/> Plan Document	<input type="radio"/> Plan Document
	<input type="radio"/> Required Notices	<input type="radio"/> Billing
	<input type="radio"/> Plan Portal Access	<input type="radio"/> Email Alerts
	<input type="radio"/> Census	<input type="radio"/> Census
Current Asset Holder		
Full Name		
Title		
Company Name		
Physical Address	Address 1:	
	Address 2:	
	City:	State:
Email Address		
Contact Number	Phone:	Fax:

## Current Recordkeeper for VEBA/115 or Pension Plan Recordkeeper for 401(h)

Full Name			
Title			
Company Name			
Physical Address	Address 1:		
	Address 2:		
	City	State:	Zip:
Email Address			
Contact Number	Phone:	Fax:	

## Payroll Vendor

Full Name			
Title			
Company Name			
Physical Address	Address 1:		
	Address 2:		
	City:	State:	Zip:
Email Address			
Contact Number	Phone:	Fax:	

## CONTRIBUTION FREQUENCY

Active Employees		Retired Employees	
Date of initial contribution:		Date of initial contribution:	
<input type="radio"/> Annual	<input type="radio"/> Weekly	<input type="radio"/> Annual	<input type="radio"/> Weekly
<input type="radio"/> Bi-Weekly	<input type="radio"/> Semi-Monthly	<input type="radio"/> Bi-Weekly	<input type="radio"/> Semi-Monthly
<input type="radio"/> Monthly	<input type="radio"/> Other:	<input type="radio"/> Monthly	<input type="radio"/> Other:

## Addendum

### PLAN PROVISIONS

#### Coverage Options

- ☐ Full Scope Option (includes Limited Purpose and Suspension options)  
☐ Exceptions (describe):

#### Dependent Information

Spouse Definition: An individual who is legally married to a participant and who is treated as a spouse under IRS Code.

Dependent Definition:

- ☐ An individual (other than the participant and spouse) with respect to whom amounts expended for medical care are excluded from the participant's gross income under Section 105(b) of the Code, as amended.  
☐ Other or additional details:

#### Healthcare Expenses (choose one)

- ☐ Maximum permitted by law (i.e., Section 213(d) medical expenses)  
☐ Exceptions:

#### Eligibility (check and complete all that apply)

- ☐ Age: ☐ Length of Service: ☐ Employment class: ☐ Retirees:  
☐ Coverage under a specified group medical plan ☐ Other:  
☐ Coverage for Spouses/Dependents: ☐ If enrolled in adopting employer's group medical plan  
☐ If enrolled in any group medical plan

Comments/Details:

#### Termination of Contributions:

- ☐ As provided in the Basic Plan Document (i.e., upon termination of employment, death, or termination of plan)  
☐ Other or additional details:

#### Termination of Participation:

- ☐ As provided in the Basic Plan Document (i.e., upon termination of employment, death, or termination of plan)  
☐ Other or additional details:

#### Benefits

- ☐ N/A ☐ Second Benefit Submission Deadlines (describe):  
☐ Expenses must be incurred: ☐ After termination of employment ☐ Additional events:

#### Post-termination of employment access

- ☐ As provided in the Basic Plan Document ☐ In lieu of COBRA, transfer to post-employment HRA  
☐ Other: ☐ Forfeit balance after claims run-out period of:

#### Post-death access by spouse & dependents

- ☐ As provided in the Basic Plan Document ☐ In lieu of COBRA, transfer to post-employment HRA  
☐ Other: ☐ Forfeit balance after claims run-out period of:

#### Forfeitures

- ☐ Plan Sponsor Discretion (annual election to offset future contributions, contribute pro-rata, or pay plan expenses)  
☐ Other:

#### Employer Contributions (check all that apply)

- ☐ One-time contribution ☐ As outlined in CBA, MOU, or prior plan document  
☐ List any changes:

#### Employee Contributions

Allowed? ☐ Yes ☐ No Contribution: ☐ Dollar ☐ Percentage  
 Maximum:

<b>Optional Contributions</b> (check all that apply)	
<input type="radio"/> Accumulated paid time Off (PTO)	<input type="radio"/> Accumulated sick time
<input type="radio"/> Other:	<input type="radio"/> Accumulated vacation time
<b>Availability for Reimbursement of Account Balance</b>	
<input type="radio"/> Active employees are claims eligible	<input type="radio"/> Upon termination of employment
<input type="radio"/> Other or additional detail:	
<b>Investments</b>	
<input type="radio"/> Plan Sponsor (employer) directed	<input type="radio"/> Participant directed
<b>Vesting</b>	
<input type="radio"/> 100% at entry date	
<input type="radio"/> Per schedule:	
<b>Provision Options in HRA</b>	
Effective date of waiver upon termination of employment:	Expiration of opt-out election:
<input type="radio"/> Date employment ends	<input type="radio"/> End of plan year
<input type="radio"/> Last day of the month in which employment ends	<input type="radio"/> N/A (opt-out election is permanent)
<input type="radio"/> Date on which coverage under the group medical plan ends	<input type="radio"/> Other:
Please provide any additional instructions	

DOCUMENTS INCLUDED		
Current plan documents (including all amendments)	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Trust documents	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Collective Bargaining Agreement/MOU	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Latest IRS Determination Letter	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Schedule of Benefits/ Summary of Benefits Coverage (SBC)	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
BPAS Sales Relationship Manager:		
Form Completed By:		
Name/Title:	Date:	
Plan Provisions approved by (TPA or Plan Sponsor Authorized Representative):		
Signature:	Date:	

BPAS Internal Use Only			
<b>Census / Eligibility Contact</b>	Full Name:		Title:
	Phone Number:	Email Address:	
<b>Billing Contact</b>	Full Name:		Title:
	Phone Number:	Email Address:	
TPA Firm Name:			
New TPA relationship to BPAS? <input type="radio"/> Yes <input type="radio"/> No		BPAS plan numbering convention:	
Dual plan separation (HRA and RHRA)? <input type="radio"/> Yes <input type="radio"/> No		PL633 coding:	PL675 coding:
PTM plan type coding:		Suppress PT Files: <input type="radio"/> Yes <input type="radio"/> No	
Online Beneficiary designation? <input type="radio"/> Yes <input type="radio"/> No		Online employee contributions? <input type="radio"/> Yes <input type="radio"/> No	

## Appendix

## ACH AUTHORIZATION

I (we) hereby authorize BENEFIT PLANS ADMINISTRATIVE SERVICES, hereinafter referred to as **BPAS**, to initiate debit entries per each daily contribution processing cycle received to the account indicated below at the depository financial institution named below, and to debit the same to such account. The BPAS debit request shows up as BPA followed by a ten digit number. This authority is to remain in full force and effect until BPAS receives written notification from me (or either of us) of its termination in such time and in such manner as to afford BPAS and financial institution a reasonable opportunity to act on it.

**By signing, I agree that I have read the “Automated Debit Policy” section below.**

Authorized Signature:

Date:

Full Name:

Title:

## FINANCIAL INSTITUTION AND ACCOUNT INFORMATION

Plan Name:

Acct Tax ID:

**CENSUS FILE DIVISIONS:** Each division that has a separate census file submission must have corresponding ACH authorization to approve debit entries. Please enter the division(s) for which this ACH Authorization will apply. If your firm does not use divisional security, and does not remit a separate census file for each of its divisions, enter **NONE**.

6 Digit BPAS Number:

Census File Division(s):

Financial Institution:

City:

State:

Zip:

Transit/ABA Number:

Account Number:

Account Type: ☐ Checking ☐ Savings

**Automated Debit Policy.** If the Company authorizes BPAS to initiate debit entries in connection with contributions, loan repayments (if applicable), and other payments made to the Plan, as directed by the Company, through an Automated Clearing House (ACH) electronic funds transfer from the account set up for this purpose, such account shall be designated by the Company on an ACH Authorization. The Company may subsequently designate another bank account by directing BPAS in writing or such other medium as may be acceptable to BPAS. The Company will be responsible for submitting contribution loan repayments and other payment data via electronic means acceptable to BPAS. The Company also directs that the Company’s completed ACH Authorization, or subsequent direction acceptable to BPAS which supersedes the original, shall serve as authorization to the bank indicated by the Company to accept any such debit entries initiated to the designated bank account. The Company agrees that it shall be solely responsible for assuring that BPAS is in receipt of the information necessary to initiate and effectuate the transfer of funds pursuant to this instruction and that the bank account designated by the Company now or in the future, contains sufficient funds to satisfy the BPAS ACH request. Further, the Company agrees and acknowledges that 1) if it should fail to make sufficient funds available in its bank account for ACH purposes, BPAS reserves the right to reverse new contribution trades in participant accounts, 2) purchases will not be considered “plan assets” until funds have actually been delivered to BPAS, and 3) if the Company fails to deliver settlement proceeds, the Company will assume full responsibility for resolving this matter with plan participants, including any financial restitution.

**Return Form to BPAS Utica Trust Department (For Your Security, DO NOT EMAIL)**

**Please ensure that all information on this form has been completed. Incomplete forms will not be accepted.** Print and **fax** the signed form to the BPAS Utica Trust Department at: (315) 292-6498. **Please do not e-mail.**

## BPAS USE ONLY

Date Rec’d:

By:

Process Date:

By:

## Appendix

## CENSUS FILE SPECIFICATIONS

Please provide a file containing the information described in the table below. The file should include data for:

- All employees currently employed
- All employees employed in the prior plan year
- All terminated employees that continue to maintain an account in the plan(s)

Hours and compensation should reflect actual hours worked and compensation earned for the prior plan year. You may omit hours and compensation for any employee hired in the current year, but please include all other fields. To ensure the security of your data, please send via secure email or upload via our SFTP site. Instructions to upload via our SFTP are found under Exhibit H. **PLEASE DO NOT EMAIL THE FILE.** **Note:** If your plan runs on a fiscal year (rather than the calendar year), we will send you a separate email requesting additional census data.

Please submit file in comma delimited (.csv) format. Follow the **Field Alignment** guidelines below:

- **Alpha Numeric fields:** Formatted as left justified text
- **Alpha Numeric blank fields:** Formatted as left justified text
- **Numeric fields:** Formatted as a Numeric with 2 decimals
- **Numeric blank fields:** Formatted as a Numeric with 0.00
- **Numeric negative fields:** Include a leading negative [Ex: negative 10.00 = -10.00]
- **Date fields:** Formatted and entered as mm/dd/yyyy

Field Requirement	Required	Optional
Social Security Number	X	
First Name	X	
Last Name	X	
Gender - M or F	X	
Address 1 (maximum 30 characters)	X	
Address 2 (maximum 30 characters)	X	
City	X	
State	X	
Zip	X	
Date of Birth	X	
Date of Hire	X	
Date of Rehire	X	
Date of Termination	X	
Div/Sub		X
Union (Y or N)	X	
Non-Resident (Y or N)	X	
Leased Employee (Y or N)	X	
Prior Plan Year Annual Compensation	X	
Prior Plan Year Annual Hours	X	
Employer Provided Email Address	X	

## Questions? Let's Talk.

1-866-401-5272  
trustsales@bpas.com  
bpas.com

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One Company. **One Call.**