BPAS

VEBA/115 Trust Installation Kit

Congratulations! You have a plan that will be converting to the **VEBA/115 Trust** 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)

***IMPORTANT NOTE:** This PDF document is prepared 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.

- ☐ Any Plan Amendments
- ☐ Basic Plan Document
- ☐ Summary Plan Description
- ☐ Most Recent Valuation
- ☐ Summary of Material Modification
- ☐ Private Letter Ruling (PLR)

Clear Form

VEBA/115 Trust Plan

Please fill in all the information as accurately as possible. The information you provide will assist in building your complete VEBA/115 Trust plan profile. This PDF document is prepared an interactive form. Please complete it electronically.

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)*	
Current Assets:	Number of Participants:	Effective Date for BPAS Trust:	
Form 990 will be prepared by:	◯ BPAS	◯ Other:	◯ N/A (per attached determination letter)
Form 5500 will be prepared by:	◯ BPAS	◯ Other:	◯ N/A (per attached determination letter)
Documents will be created by:	◯ BPAS	◯ Other:	◯ 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	☐ Same as corporate address		☐ Same as corporate address	
	Address 1:		Address 1:	
	Address 2:		Address 2:	
	City:		City:	
	State:	Zip:	State:	Zip:
Email Address				
Contact Number	Phone:	Fax:	Phone:	Fax:
Contact Type *(check all that apply)*	☐ Principal/Owner ☐ Payroll ☐ Plan Document ☐ Required Notices ☐ Plan Portal Access	☐ Human Resources ☐ Census ☐ Billing ☐ Email Alerts ☐ Authorized Signer	☐ Principal/Owner ☐ Payroll ☐ Plan Document ☐ Required Notices ☐ Plan Portal Access	☐ Human Resources ☐ Census ☐ Billing ☐ Email Alerts ☐ 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:	**Zip:**	State:	Zip:
Email Address				
Contact Number	Phone:	Fax:	Phone:	Fax:
Contact Type *(check all that apply)*	☐ Plan Document ☐ Required Notices ☐ Plan Portal Access	☐ Billing ☐ Email Alerts	☐ Plan Document ☐ Required Notices ☐ Plan Portal Access	☐ Billing ☐ 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:	Zip:	State:	Zip:
Email Address				
Contact Number	Phone:		Fax:	
Contact Type *(check all that apply*	☐ Plan Document ☐ Required Notices ☐ Plan Portal Access	☐ Billing ☐ Email Alerts ☐ Census	☐ Plan Document ☐ Required Notices ☐ Plan Portal Access	☐ Billing ☐ Email Alerts ☐ Census
Current Asset Holder				
Full Name				
Title				
Company Name				
Physical Address	Address 1:			
	Address 2:			
	City:		State:	Zip
Email Address				
Contact Number	Phone:		Fax:	

Current Recordkeeper			
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:	
◯ Annual	◯ Weekly	◯ Annual	◯ Weekly
◯ Bi-Weekly	◯ Semi-Monthly	◯ Bi-Weekly	◯ Semi-Monthly
◯ Monthly	◯ Other:	◯ Monthly	◯ 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
◯ Other:
◯ In lieu of COBRA, transfer to post-employment HRA
◯ Forfeit balance after claims run-out period of:

Post-death access by spouse & dependents

◯ As provided in the Basic Plan Document
◯ Other:
◯ In lieu of COBRA, transfer to post-employment HRA
◯ 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:

Optional Contributions (check all that apply)

☐ Accumulated paid time Off (PTO) ☐ Accumulated sick time ☐ Accumulated vacation time
☐ Other:

Availability for Reimbursement of Account Balance

◯ Active employees are claims eligible ◯ Upon termination of employment ◯ Other or additional detail:

Investments

◯ Plan Sponsor (employer) directed ◯ Participant directed

Vesting

◯ 100% at entry date
◯ Per schedule:

Provision Options in HRA

Effective date of waiver upon termination of employment:
◯ Date employment ends
◯ Last day of the month in which employment ends
◯ Date on which coverage under the group medical plan ends

Expiration of opt-out election:
◯ End of plan year
◯ N/A (opt-out election is permanent)
◯ Other:

Please provide any additional instructions

	DOCUMENTS INCLUDED
Current plan documents (including all amendments)	◯ Attached ◯ Not Applicable
Trust documents	◯ Attached ◯ Not Applicable
Collective Bargaining Agreement/MOU	◯ Attached ◯ Not Applicable
Latest IRS Determination Letter	◯ Attached ◯ Not Applicable
Schedule of Benefits/ Summary of Benefits Coverage (SBC)	◯ Attached ◯ 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

Census / Eligibility Contact	Full Name:		Title:
	Phone Number:	Email Address:	
Billing Contact	Full Name:		Title:
	Phone Number:	Email Address:	
TPA Firm Name:			
New TPA relationship to BPAS? ◯ Yes ◯ No	BPAS plan numbering convention:		
Dual plan separation (HRA and RHRA)? ◯ Yes ◯ No	PL633 coding:		PL675 coding:
PTM plan type coding:	Suppress PT Files: ◯ Yes ◯ 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. 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.

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BPAS

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One Company. One Call.