WEST VIRGINIA LABORERS PROFIT SHARING PLAN

PARTICIPANT APPLICATION FOR HARDSHIP WITHDRAWAL

PLAN OFFICE

WEST VIRGINIA LABORERS
PROFIT SHARING PLAN
ONE UNION SQUARE
SUITE 200
CHARLESTON, WV 25302

Phone: (304) 342-5142
Fax: (304) 342-2610

Section I: Participant Information

Name: _____ Soc. Sec. No: _____

Address: _____ Birth Date: _____

City: _____ State: _____ Zip Code: _____ Telephone: _____

Last Employer: _____ Last Day Worked: _____

Marital Status: ☐ Married ☐ Not married Local Union No: _____

Balance: _____ As of _____

Section II: Application for Hardship Withdrawal

(Check and/or enter the reason(s) for the hardship withdrawal and enter the amount you are requesting as a hardship withdrawal to satisfy your financial need. You may also enter an amount you estimate is necessary to pay income taxes and penalties on the hardship withdrawal. You must attach evidence of your financial need.)

I hereby apply for a hardship withdrawal from my Account under the Profit Sharing Plan on account of the following financial need(s):

☐ Unreimbursed medical expenses or expenses necessary to obtain medical care $_____

☐ Tuition, fees and room and board for post-secondary education $_____

☐ Payment necessary for coverage under the West Virginia Laborers Health & Welfare Plan ($200 minimum) $_____

☐ Payment of any financial need after 180 days of active service in the military reserves ($10,000 maximum) $_____

☐ Purchase of first principal residence ($10,000 maximum) $_____

Plus Estimated Income/Penalty Taxes (optional) + $_____

Total Dollar Amount of Hardship Withdrawal Request = $_____

Section III: Federal Income Tax Withholding Election

I hereby elect the following federal income tax withholding for the Hardship Withdrawal:

☐ No withholding of federal income tax; or

☐ Withholding of federal income tax equal to _____% of the Hardship Withdrawal.

Section IV: Participant Signature and Certification

I hereby certify that:

1. the information furnished above is true and correct to the best of my knowledge; and

2. the total amount of my hardship withdrawal request is not more than my financial need plus reasonably expected income and penalty taxes; and

3. my financial need cannot be satisfied from other reasonably available financial resources.

I hereby authorize all actions necessary to implement the elections made above. I understand that all payments are governed by the document for the Profit Sharing Plan and that I must hold any payments not provided for in the document for the benefit and reimbursement of the Plan.

Signature: _____ Date: _____
(Sign in Presence of Notary Public)

State of: _____. County of: _____. On _____, ___, 20____, the above-named Participant appeared before me and signed this Participant Application for Distribution.

[SEAL]

Notary Public: _____

Commission Expires: _____

Section V: Plan Office Use Only

A. Application and Instructions ☐ mailed ☐ delivered to Participant on _____ by _____.

B. Application received from Participant on _____ by _____.

C. Distribution approved / denied on _____ by _____.

D. Check issued on _____ by _____.

WEST VIRGINIA LABORERS PROFIT SHARING PLAN

PLAN OFFICE

WEST VIRGINIA LABORERS
PROFIT SHARING PLAN
ONE UNION SQUARE
SUITE 200
CHARLESTON, WV 25302

Phone: (304) 342-5142
Fax: (304) 342-2610

INSTRUCTIONS FOR PARTICIPANT APPLICATION FOR HARDSHIP WITHDRAWAL

Application

Use the Participant Application for Hardship Withdrawal to apply for a hardship withdrawal from of your Account to satisfy a financial need that cannot be satisfied from other financial resources reasonably available to you.

Please print or type all information (except for the required signatures). File the completed Application with the Plan Office at the above address, along with evidence of your financial need.

The amount of a withdrawal will be based on the value of your Account as of the preceding March 31, as adjusted for subsequent employer contributions and distributions (and withdrawals).

Application for Hardship Withdrawal - Section II of the Application

Check one or more boxes to specify the financial need or needs for which you are requesting a hardship withdrawal and enter the dollar amount you wish to withdraw to satisfy the financial need. The dollar amount you enter cannot exceed the amount of the financial need. The eligible financial needs are listed below.

If you wish, you may also enter a dollar amount that you estimate is necessary to pay federal, state, and local income taxes and penalties reasonably expected to result from the hardship withdrawal.

The total dollar amount of your hardship withdrawal request should equal the dollar amount of the hardship withdrawal you request to satisfy your financial need plus any dollar amount you request to pay estimated income taxes and penalties on the hardship withdrawal.

Medical Expenses. The amount must be necessary to pay for medical care provided to you or your spouse or dependent, or must be necessary to obtain medical care for you or your spouse or dependent. The medical expenses cannot be reimbursable by insurance or under a medical plan. Medical expenses for this purpose are medical expenses deductible on your federal income tax return under Internal Revenue Code § 213(d) (without regard to the 7.5% of adjusted gross income limitation). Attach as evidence of your financial need, copies of bills, receipts or estimates from health care providers or facilities. If any amount has been reimbursed by an insurance company or medical plan, include the explanation of benefits provided by the insurance company or medical plan.

Educational Expenses. The amount must be necessary to pay tuition, related educational fees and/or room and board for up to the next 12 months of post-secondary education for you or your spouse, child or dependent. Attach as evidence of your financial need, a copy of a bill or receipt for the tuition, related fees and/or room and board. Indicate all expected or received financial aid or student assistance.

Health & Welfare Plan Coverage. The amount must be necessary to maintain coverage under the West Virginia Laborers Health & Welfare Plan for the next coverage period, but only if that amount is $200 or more. Attach as evidence of your financial need, a copy of a bill or statement showing the amount necessary to maintain the coverage.

Service in the Reserves. The amount must be necessary to satisfy a financial need of you or your spouse, child or dependent after you have completed 180 or more days of active service in the military reserves. The maximum withdrawal is $10,000, and only one such withdrawal is permitted during each (April 1 to March 31) Plan Year.

Purchase of First Principal Residence. The amount must be necessary for and directly related to the purchase of your principal residence, excluding mortgage payments. This withdrawal is available only if you are first-time homebuyer. The maximum withdrawal is $10,000. Attach as evidence of your financial need, a copy of an executed agreement of sale.

Federal Income Tax and Withholding Election - Section III of the Application

Your hardship withdrawal will be subject to federal income tax. Also, if you are younger than age 59½ at the time of the withdrawal, the withdrawal will be subject to an additional 10% federal income tax, unless an exception applies. Information on the additional 10% federal income tax can be found in IRS Form 5329 and IRS Publication 575.

You can elect to have any percentage withheld from the hardship withdrawal as your federal income tax withholding or to have no amount withheld.

If you elect no withholding, or if you do not have enough withheld from the withdrawal, you may be responsible for the payment of quarterly estimated tax payments. You may be subject to tax penalties if your withholding and estimated tax payments for your income for a year are insufficient. Information on the withholding of federal income tax can be found in the instructions to IRS Form W-4P.

Participant Signature and Certification - Section IV of the Application

Note that by your signature you certify that you have a financial need that cannot be satisfied by other financial resources reasonably available to you. The Board of Trustees has the authority to request evidence and documentation regarding your financial need and financial resources.

IRS Required Information

Under current IRS rules:

- You have the right to a 30-day period after you are provided with these Instructions to consider your Application for Hardship Withdrawal. You may waive that right by filing the Application within this 30-day period.

- You cannot be provided with these Instructions any earlier than 180 days before the date the withdrawal is made. Accordingly, if, when you return the Application, the withdrawal cannot be made within 180 days of the date you were provided with these Instructions, the withdrawal will not be made and you will have to obtain another set of Instructions before you can apply for the hardship withdrawal.

You have the right to defer the distribution of your Account, which includes the right not to take a hardship withdrawal from your Account.

If you do not take a withdrawal, the entire amount of your Account will continue to be invested on a tax-deferred basis in the trust fund under the Profit Sharing Plan and will continue to be credited and charged with earnings, gains, losses and expenses accordingly.

If you apply for and receive a withdrawal now, the withdrawal will cease to be so invested in the trust fund for the Profit Sharing Plan, and will be subject to federal income tax, including potentially the additional 10% federal income tax noted above. The withdrawal cannot be rolled over to an IRA or another plan.

WEST VIRGINIA LABORERS PROFIT SHARING PLAN

PAYMENT RESIDENCY REPRESENTATIONS

PLAN OFFICE

WEST VIRGINIA LABORERS
PROFIT SHARING PLAN
ONE UNION SQUARE
SUITE 200
CHARLESTON, WV 25302

Phone: (304) 342-5142
Fax: (304) 342-2610

Section I: Participant/Beneficiary Information

The address you indicate is where checks and tax forms will be mailed.

Name: _____ Soc. Sec. No: _____

Address: _____ Birth Date: _____

City: _____ State: _____ Zip Code: _____ Telephone: _____

Section II: Residency Information

My tax status is (select one of the following): ☐ U.S. Citizen / Resident Alien ☐ Non-Resident Alien

Is payment to be delivered to an address or account outside the United States: _____ Yes _____ No

If you are a Non-Resident Alien, please complete IRS Form W8-BEN by following the instructions provided, and include with your Distribution Application. If IRS FormW8-BEN is not included, withholding will be processed at 30% of the gross payment. If you are a U.S. Citizen / Resident Alien, please complete the IRS Form W4-P by following the instructions provided and include with your Distribution Application. If IRS Form W-4P is not included, withholding will be processed assuming a marital status of married filing jointly with 3 exemptions.

Section III: Participant Signature and Certification

I hereby certify that the information furnished above is true and correct to the best of my knowledge. My direct deposit authorization (if any) shall remain in effect until such time as I provide written notification to the Plan, and the Plan has a reasonable opportunity to act on it.

Signature: _____ Date: _____

Section IV: Plan Office Use Only

Received on _____ by _____.

WEST VIRGINIA LABORERS' TRUST FUND

ONE UNION SQUARE
SUITE 200
CHARLESTON, WEST VIRGINIA 25302

PHONE (304) 342-5142
FAX (304) 342-2610
STEVEN L. SMITH, Administrative Manager
JUDITH LILLY, Executive Secretary

FIRST TIME HOMEBUYER

I, _____, hereby attest that I am a First Time home Buyer and have never owned a Principal Residence and am applying to receive funds from my Profit Sharing Plan Account under the applicable provision that allows such a withdrawal. I further understand that the Plan's definition of a Principal Residence is the *primary* location that a person inhabits. It doesn't matter whether it is a house or a trailer, as long as it is where you live most of the time.

Signature: _____ Date: _____

(Sign in the presence of a Notary Public)

State of: _____ County of: _____. On _____ ____, 20____, the above-named Participant appeared before me and signed this affadavit.

[SEAL]

Notary Public: _____

Commission Expires: _____

Enrollment Form for the West Virginia Laborers' Insurance and Pension Trust Fund

The West Virginia Laborers' Trust Funds have received hours and contributions on your behalf. You may be eligible for health insurance and/or retirement benefits. Please complete this document and mail it to our office at: 1 Union Square, Suite 200, Charleston, WV 25302. You may fax it to 304-342-2610. You may also fill out the online Enrollment Form through our Participant Portal at http://www.wvlaborers.com/. If you are mailing in the form, please provide a copy of the following documents in order for us to process your, and any applicable dependents', health insurance eligibility, pension eligibility, and annuity eligibility (if applicable).

- ☐ Marriage Certificate (if you are married)
- ☐ Legal Divorce Documents (to remove ex-spouse from pension)
- ☐ Birth Certificates (for all children you want covered)
- ☐ Adoption Affidavit (for any adopted or step children you want covered)

Full Legal Name: _____ Date of Birth: ____/____/_____

Home Mailing Address: _____

Circle one: Single / Married / Widow(er)

Local Union* No. _____

Social Security Number: _____-____-_____

Local Entry Date: ____/____/_____

Designation of Beneficiary:

Full Legal Name: _____ Relationship: _____

Home Mailing Address: _____

Social Security Number: _____-____-_____

*Please note that if you are married and have designated someone other than your spouse to receive your death benefits, the Plan can not honor your designation unless both you and your spouse complete additional documentation. Please contact the Fund Office at 304-342-5142 for more information. You may change your beneficiary at any time by providing the proper documentation.

For health insurance coverage, list below the information for your spouse and all dependents under 26 years of age.

Name	Relationship	Social Security #	Date of Birth

*If you are a member of an out-of-state local, please contact the Fund Office to complete the appropriate reciprocal documents.