

# WEST VIRGINIA LABORERS PROFIT SHARING PLAN

## INSTRUCTIONS FOR 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

### 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'**  
BENEFIT FUNDS

One Union Square, Suite 200  
Charleston, WV 25302

(304) 342-5142 TEL • (304) 342-2610 FAX  
Nathanael Aylestock, ADMINISTRATIVE MANAGER

## ***Empower Fees and Payment Options Effective September 1, 2024***

Empower applies the following fees to distributions:

Hardship Distributions	\$65 per distribution
Non-Hardship Distributions	\$75 per distribution

You may elect an expedited payment for an additional charge.  
Please select one of the following:

_____ No expedited payment	\$ 0
_____ Direct Deposit (attach a voided check)	\$15
_____ Express Delivery (1-2 days)	\$30

Please complete and return with your entire completed application.

### MANAGEMENT TRUSTEES

Mary Prim, SECRETARY  
Jim Carney  
Clinton Suggs  
Timothy E. Gooden  
Dan Loy  
Kelly Young

### LABOR TRUSTEES

Jessie King, CHAIRMAN  
Calvin Brogan  
Matt Freeland  
Justin Gray  
Jason Hershman  
Byron McGrady

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ONE UNION SQUARE  
SUITE 200  
CHARLESTON, WV 25302

## PARTICIPANT APPLICATION FOR HARDSHIP WITHDRAWAL

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: \_\_\_\_\_

### 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 \_\_\_\_\_.



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Nathanael Aylestock, ADMINISTRATIVE MANAGER

## AFFIDAVIT for HARDSHIP WITHDRAWAL INSURANCE PREMIUM

I, \_\_\_\_\_, the undersigned participant, acknowledge that I am applying for a Hardship Withdrawal from the WV Laborers' Profit Sharing Plan for payment of my Insurance Premium to the WV Laborers' Health & Welfare Fund for the Months of \_\_\_\_\_. I certify that there are no outstanding hours pending and my last date of employment was \_\_\_\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

State of \_\_\_\_\_

County of \_\_\_\_\_

Sworn before me and subscribed in my presence this \_\_\_\_ day of \_\_\_\_\_, 20\_\_

\_\_\_\_\_  
Affix Stamp or Seal

\_\_\_\_\_  
Notary Public

My Commission expires \_\_\_\_\_

### MANAGEMENT TRUSTEES

Mary Prim, SECRETARY  
Jim Carney  
Clinton Suggs  
Timothy E. Gooden  
Dan Loy  
Kelly Young

### LABOR TRUSTEES

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## PAYMENT RESIDENCY REPRESENTATIONS

### 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 Form W8-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 \_\_\_\_\_.

## Enrollment Form for the West Virginia Laborers' Profit Sharing Plan

The West Virginia Laborers' Profit Sharing Plan has received hours and contributions on your behalf. You may be eligible for 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/>.

Full Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Mailing Address: \_\_\_\_\_

Circle one: Single / Married / Widow(er) Local Union\* No. \_\_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Local Entry Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone Number (Circle one - Home / Mobile): \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Email Address: \_\_\_\_\_@\_\_\_\_\_.\_\_\_\_\_

Participant's Signature: \_\_\_\_\_

### 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 cannot 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.