**Internal Revenue Service**

District
Director

**Department of the Treasury**

450 Golden Gate Avenue
Room 4209 -Box 36001 - sf 4446
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**Person to Contact:** L. Yee

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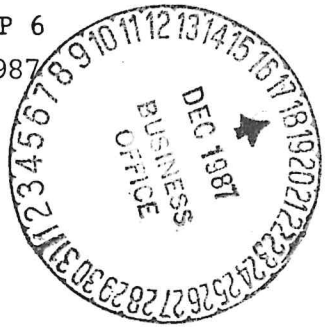
**Refer Reply to:** EP/EO: GP 6

**Date:** December 10, 1987

Everett School Employee Benefit Trust
4730 Colby Avenue
Everett, WA 98023




Dear Applicant:

We are considering your application for recognition of exemption from federal income tax as an organization described in section 501(c)(9) of the Internal Revenue Code. On August 28, 1987, the Internal Revenue Service published, as part of the Internal Revenue Manual, "Safe harbor guidelines" for ruling on applications for exemption under section 501(c)(9).

Generally, the "safe harbor guidelines" provide that a favorable ruling or determination letter will be issued if the benefits provided through a Voluntary Employees Beneficiary Association (VEBA) are the same for all employees. Seasonal and half-time employees, employees under the age of 21 or with less than 3 years of service, and employees covered under a collective bargaining agreement can be excluded. Income replacement benefits (such as life insurance, disability, severance pay, or supplemental unemployment benefits) provided as a uniform percentage of compensation would ordinarily meet the "safe harbor guidelines". If the benefits provided through your VEBA meet safe harbor guidelines and you otherwise qualify for exemption, a favorable ruling will be issued. If not, it may be necessary to continue to suspend action on your application.

Please provide the information requested on the attached questionnaires over the signature of an officer, director, trustee, or other properly authorized person. The information requested is needed to determine whether or not your VEBA falls within the guidelines and otherwise meets the requirements of section 501(c)(9) of the Code and the regulations thereunder.

We will defer action on your request for 21 days of the date of this letter to enable you to submit the requested information. If we do not hear from you within that time, we will assume that you do not want us to consider your request further and will close your case.

If you have any questions, please contact the person whose name and address are shown above.

Thank you for your cooperation.

Sincerely yours,

Please respond to the questions checked below over the signature of a principal officer of the Trust:

1. Please provide the total number of employees of the sponsoring employer who are not covered by you. Of this number, how many are described in section 505(b)(2) of the Code?

2. Are the employees who are non-participants and not described in section 505(b)(2) of the Code provided similar benefits by the employer? Please submit a detailed description.

3. Please state the number of employees of the sponsoring employer who are entitled to receive benefits.

4. Please submit complete financial statements for current year and 3 preceding years.

5. Please submit copies of all insurance policies being used to provide benefits. If the policies are not issued to the Voluntary Employees Beneficiary Association (VEBA) as policy holder, are you willing to change the policies so that they are in the name of the VEBA?

6. Other than insurance contracts or policies, if the VEBA a party to any contracts, leases, or other agreements? If so, submit a copy of such agreement.

7. Please indicate whether or not there has been any substantive changes in the eligibility requirements for benefits or benefits funded by the VEBA in 1985, 1986 and 1987. If so, please furnish a copy of such changes.

8. To the extent not previously submitted, provide copies of all summary plan descriptions or other booklets or materials describing the benefits you provide.

9. If the sponsoring employer is affiliated through stock ownership with any other employer, please describe the relationship and the percentage of ownership.

10. List any new subsidiaries now covered by your VEBA. If the employees of such subsidiaries receive different benefits from the other employees, please state why. Also, please submit a schedule of salary and benefits received by such employees.

11. Section 1.501(c)(9)-2(a)(1) of the regulations requires that the members of a Voluntary Employees Beneficiary Association (VEBA) share an employment related common bond. Please explain the nature of employment related common bond shared by employee-members. If you claim that the employee-members are employees of employers in the same line of business in the same geographic locale, please state the name, address, and the line of business of each participating employer.

12. Is participation in your plan voluntary? What action, if any, must your employees take to participate in your plan? Participation is automatic, however employees must complete enrollment applications.

13. Are any employee contributions required for any benefits provided by your Voluntary Employee Beneficiary Association (VEBA)? If so, specify all contributions required, including dollar amounts. See Below

14. Describe other benefits provided. (Other than "life, accident and sick benefits).

15. Please provide copies of policies or/and plans which set forth provisions, eligibility rules and administration provisions. (Ordinarily a summary booklet is not sufficient to disclose all the terms and benefits set forth in the policies and/or plans.)

16. Are any of your benefits self-funded? If so, state which benefits.

17. With respect to any of your benefits that are self-funded, please provide a copy of any report providing actuarial assumptions and calculations used to determine the contributions to the Voluntary Employees Beneficiary Association.

18. If any of your benefits are provided pursuant to the terms of a Collective Bargaining Agreement, please submit a copy of such agreement.

19. Please indicate whether your Voluntary Employees Beneficiary Association provides for the payment of life benefits that have an effective date which coincides with the date of employee's retirement. (Retired Life Reserve).

20. With respect to self-funded benefits, please provide copies of any specific excess and aggregate excess insurance; life and specific and aggregate reinsurance; or similar stop-loss insurance policies.

Reply to 13: Employees have a choice from three medical plans. Full time employees pay no premium for two of the plans, but if they select the HMO which has a higher premium cost, they pay the difference based on number of dependents which ranges from $21.95 to $49.60 per month. Part-time employees pay a portion of their medical premium based on their full time equivalency percentage. If they have an FTE of 60% they pay 40% of the premium.

21. With respect to your group term life insurance benefits, please provide the following information:

(a) Total number of employees of sponsoring employer;

(b) Total number of employees eligible for coverage;

(c) Total number of employees actually covered;

(d) If your responses to (a), (b), and (c) above are not equal, please state the number of employees excluded because they:

1. have less than 3 years of service;

2. are part-time or seasonal employees;

3. are covered under a collective bargaining agreement under which group term life insurance benefits were the subject of good faith bargaining; **or**

4. are nonresident aliens with no U.S. source income from the employer.

(e) Please provide the number of employees who are participants and who are "key employees" as defined in IRC 416(i). "Key employees" are those employees who are:

1. Officers of the employer with annual compensation of more than $45,000;

2. One (1) of the ten (10) employees having annual compensation of more than $45,000 and owning the largest interests in the employer.

3. A 5% owner of the employer; or n/a

4. A 1% owner of the employer with annual compensation greater than $150,000.

22. With respect to your self-funded medical benefits, please provide the following information:

(a) Total number of employees of the sponsoring employer;

(b) Total number of employees eligible for coverage;

(c) Total number of employees actually covered;

(d) If your responses to (a), (b) and (c) above are not equal; please state the number of employees excluded because they:

1. have less than 3 years of service;

2. are part-time or seasonal employees;

3. are covered under a collective bargaining agreement under which medical benefits were subject of good faith bargaining;

4. are nonresident aliens with no U.S. source income from the employer; or

5. are excluded from coverage for some other reason other than those specified in 1, 2, 3, or 4 above. State reasons.

(e) Please provide the number of employees who are participants in the plan and who are considered highly compensated employees. Highly compensated employees are those individuals who are: **IRC 105(h)(5)

1. the 5 highest paid officers of the employer;

2. a 10% owner of the employer; or

3. among the highest paid 25% of employees.

23. With respect to the below listed benefits.....

1. Dental Benefits
2. Accidental death & Dismemberment
3. Long-term Disability
4. Short-term Disability

Please provide the following information:

(a) Total number of employees of sponsoring employer;

(b) Total number of employees eligible for coverage;

(c) Total number of employees actually covered;

(d) If your responses to (a), (b), and (c) above are not equal; please state the number of employees excluded because they:

1. have less than 3 years of service;

2. are part-time or seasonal employees;

3. are covered under a collective bargaining agreement under which listed benefits were the subject of good faith bargaining;

4. are nonresident aliens with no U. S. source income from employer; or

5. are excluded from coverage for some other reason other than those categories specified in 1, 2, 3, and 4 above. State reasons.

(e) Please state the number of employees who participants in the plan and who are considered highly compensated employees. Highly compensated employees under this caption are those individuals who are:

1. the 5 highest paid officers of the employer;

2. a 10% owner of the employer; or

3. are among the highest paid 10% of the employees.

24. The last page of your Trust Agreement does not have the date the Trust was adopted. Please submit a copy of the page of your Trust Agreement with the adoption date.