Health Coverage Tax Credit

Registration Form

HCTC
Federal • State • Private Industry
Health Coverage
Tax Credit

Privacy Act and Paperwork Reduction Act Notice

The Privacy Act of 1974 and the Paperwork Reduction Act of 1995 require that when we ask you for information we must first tell you our legal right to ask for the information, why we are asking for it, and how it will be used. We must also tell you what could happen if we do not receive it and whether your response is voluntary, required to obtain a benefit, or mandatory under the law.

We ask for the information on this form to carry out the Internal Revenue laws of the United States. If you are eligible, section 35 of the Internal Revenue Code allows a credit for payments you made to buy certain types of health coverage during the tax year. Section 7527 lets you authorize your health coverage provider to receive this credit in advance in the form of monthly payments from the Internal Revenue Service.

The information you submit is used to determine if you qualify for the advance payment of the Health Coverage Tax Credit (HCTC). If you fail to provide the information, or provide inaccurate information, your application may be denied. However, you may still qualify for the HCTC when you file your federal tax return.

The estimated average time to complete this form is 30 minutes. You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may be material in the administration of any Internal Revenue laws.

Generally, tax returns and return information (tax information) are confidential, as stated in Code section 6103. However, Code section 6103 allows or requires the Internal Revenue Service to disclose or give the information to others as described in the Code. For example, we may give the information provided to us to your health plan administrator for the purposes of the HCTC program. We may disclose the information you provide to contractors for administrative purposes. We may also disclose this information to the Department of Justice, to enforce the tax laws, both civil and criminal; to other federal agencies; to states, the District of Columbia, and U.S. commonwealths or possessions in order to carry out their tax laws; and to certain foreign governments under tax treaties they have with the United States.

Please keep a copy of this notice for your records. It may help you if we later ask you for other information. If you have any questions about the rules for filing and giving information, please call the HCTC Customer Contact Center at 1-866-628-HCTC (1-866-628-4282). TDD/TTY callers, please call 1-866-626-HCTC (1-866-626-4282).

If you have any comments concerning the accuracy of the time estimate to complete this form or suggestions to make this form simpler, we would be happy to hear from you. You can write to the Tax Forms Committee, Western Area Distribution Center, Rancho Cordova, CA 95743-0001. DO NOT send the form to this office.

Health Coverage Tax Credit Registration Form

OMB No. 1545-1842

The Health Coverage Tax Credit (HCTC) program must receive this form and the requested documents in order to process your registration.

Before you begin:

- Read the HCTC Program Kit to obtain definitions and to understand the eligibility requirements for you and your family members.
- Locate the health plan invoice(s) for you and any qualified family members and, if applicable, your COBRA election letter.
- Complete Step 4 in the Program Kit, "Determining Your Payment Responsibility," to estimate how much the HCTC will contribute and how much you must contribute to the cost of your qualified health plan.

Instructions:

1. Type or print your answers legibly in black ink *(if your answers are not legible, the form can not be processed).*
2. Enter your Social Security Number (SSN) or Tax Identification Number (TIN) at the bottom of each page where indicated.
3. Read the instructions for each section to understand what type of information to provide in the section.
4. Enter only valid U.S. addresses where address information is required.
5. Enter "N/A" in any field that does not apply to you or to your qualified family member(s).
6. Sign and date this form on page 6.
7. Keep a copy of this completed registration form and any required documents for your personal records.

Part I: Complete This Part to Provide Information About You

YOUR INFORMATION			
1. SSN or TIN	2. Date of Birth (mm/dd/yyyy)		
3. Last Name	4. First Name	5. Middle Name	6. Suffix (Jr., II)
7. Mailing Address	8. City	9. State/Territory	10. Zip
11. Telephone Number (Include area code and extension) Primary / Alternate	12. Preferred Language For Mailings (Mark only one of the following)	☐ English ☐ English - Large Print ☐ Spanish ☐ Spanish - Large Print ☐ Braille	

Part II: Complete This Part to Determine Your Eligibility

1. Are you any of the following:

No	Yes	(Check all that apply.)
☐	☐	Eligible for a Trade Readjustment Allowance (TRA) under the Trade Adjustment Assistance (TAA) program.
☐	☐	Receiving benefits under the Alternative Trade Adjustment Assistance (ATAA) program
☐	☐	Receiving a pension benefit from the Pension Benefit Guaranty Corporation (PBGC)

Did you answer "Yes" to any of the choices in question 1?

☐ No. Stop; you are not eligible to register for the advance credit at this time.

☐ Yes. Go to question 2.

2. Are you currently any of the following:

No	Yes	(Check all that apply.)
☐	☐	Enrolled in a health plan maintained by an employer or former employer that pays at least 50% of the cost of coverage
☐	☐	Entitled to Medicare Part A or enrolled in Medicare Part B
☐	☐	Enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP)
☐	☐	Enrolled in the Federal Employees Health Benefits Program (FEHBP)
☐	☐	Entitled to health coverage through the U.S. military health system (TRICARE/CHAMPUS)
☐	☐	Covered by a spouse's employer-sponsored health plan that pays at least 50% of the cost of coverage

Did you answer "Yes" to any part of question 2?

☐ No. Go to question 3.

☐ Yes. Stop; you are not eligible to register for the advance tax credit at this time.

3. Can you be claimed as a dependent on someone else's 2003 federal tax return?

☐ No. Go to question 4.

☐ Yes. Stop; you are not eligible to register for the advance tax credit at this time.

4. Are you imprisoned under federal, state or local authority?

☐ No. Go to question 5.

☐ Yes. Stop; you are not eligible to register for the advance tax credit at this time.

5. Are you covered by a qualified health plan?

☐ No. Stop; you are not eligible to register for the advance tax credit at this time.

☐ Yes. Go to question 6.

6. Is your qualified health plan sponsored by your spouse's employer?

☐ No. Go to question 7.

☐ Yes. Stop; you are not eligible to register for the advance tax credit at this time. However, if the employer pays for less than 50% of the cost of coverage, you may be able to claim the HCTC when you file your federal tax return.

7. Check the box next to the qualified health plan you have.

☐ COBRA continuation coverage (where the employer/former employer pays less than 50% of the cost of coverage)

☐ HCTC state-qualified health plan

☐ Individual coverage that you were enrolled in for at least 30 days prior to separation from the job that made you TRA eligible, ATAA eligible, and/or PBGC eligible.

Claiming the Credit for Qualified Family Members

See Step 1 in the HCTC Program Kit for the definition of a qualified family member before answering question 8.

8. Do you have any qualified family members for whom you wish to claim the advance tax credit?

☐ No. Skip questions 9, 10 and 11 and go to **Part III** on page 5.

☐ Yes. Go to question 9.

9. Are any of the family members for whom you wish to claim the advance tax credit:

No	**Yes**	(Check all that apply.)
☐	☐	Enrolled in a health plan maintained by an employer or former employer that pays at least 50% of the cost of coverage
☐	☐	Entitled to Medicare Part A or enrolled in Medicare Part B
☐	☐	Enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP)
☐	☐	Enrolled in the Federal Employees Health Benefits Program (FEHBP)
☐	☐	Entitled to health coverage through the U.S. military health system (TRICARE/CHAMPUS)

Did you answer "Yes" to any part of question 9?

☐ No. Go to question 10**.**

☐ Yes. If you answered yes to any part of question 9 for a family member, that family member does not meet the definition of a qualified family member and you will not be able to claim the advance tax credit for them at this time.

10. Are all of your qualified family members covered by qualified health plans?

☐ No. Stop; if a family member is not covered by a qualified health plan, that family member does not meet the definition of a qualified family member and you will not be able to claim the advance tax credit for them at this time. Go to **Part III** on page 5.

☐ Yes. Go to question 11.

11. Are all of your qualified family members covered on your health plan policy?

☐ No. Complete **Part III** of this form to provide information about your qualified health plan. For qualified family members on your health plan policy, fill out **Part IV** of this form. For qualified family members on a qualified policy separate from yours, fill out **Part V** of this form.

☐ Yes. Complete **Part III** of this form to provide information about your qualified health plan. For qualified family members on your health plan policy, fill out **Part IV** of this form.

Part III: Complete This Part to Provide Information About Your Qualified Health Plan

1. Fill out this section to provide information about your qualified health plan.
2. You must also include a record of your qualified health plan premium amount when you submit this form. This allows the HCTC program to verify your health plan information.
   - COBRA – Include a copy of your COBRA election letter and a copy of your current month's health plan invoice.
   - HCTC state-qualified or qualified individual coverage – Include a copy of your current month's health plan invoice.
3. Your health plan invoice must list premium amounts for non-qualified family members separately from the premium amounts for you and the qualified family members on your health plan policy.

   If it does not, then you will need to include a letter from your health plan administrator defining the premium amount for only you and your qualified family members.
4. Your health plan invoice must list any exceptions (for example, vision and dental coverage) you pay for yourself and the qualified family members on your health plan policy separately from the major medical expenses/premiums.

   If it does not, then you will need to include a letter from your health plan administrator that provides the amount for only the major medical expenses/premiums.
5. You must complete the worksheet on **page 6** to estimate the HCTC-eligible premium amount for you and all qualified family members on your health plan policy.
6. Fill out **Part IV** to provide information for qualified family members on your health plan policy. Fill out **Part V** for all qualified family members who have their own qualified policy.

Your Qualified Health Plan Information		
1. Member ID	2. Group ID	3. Policy ID
4. Policy Holder's Name (Last, First, Suffix)	5. Policy Holder's SSN or TIN	

If your qualified health plan is COBRA, you must also provide the following information:

COBRA Health Plan Administrator	
1. Former Employer/Health Plan Administrator	2. Former Employer/Health Plan Administrator Telephone Number

Estimating the HCTC-Eligible Premium Amount for You and All Qualified Family Members on Your Health Plan Policy

1. Use this worksheet to estimate your HCTC-eligible monthly premium amount. You will need your most recent health plan invoice.
   - Your eligible premium amount does not include non-qualified family members.
   - Your eligible premium amount does not include exceptions (for example, vision and dental coverage).
   - The HCTC will pay for 65% of your actual eligible premium amount.
2. Refer to Step 4 in the Program Kit to estimate your payment responsibility.

1. Enter the total health plan premium that you pay per month for yourself and any qualified family members. . . . . $ _____.

2. Enter the total of any premiums you pay per month for exceptions (for example, vision and dental coverage) . . . . . $ _____.

3. Subtract line 2 from line 1. This is your monthly estimated eligible premium amount. . . . . $ _____.

THIRD PARTY DESIGNEE

A third party designee is someone you would like to authorize to access and update your HCTC account.

If you want to allow a friend, family member, or any other person you choose to discuss your HCTC account with the HCTC program, check the "Yes" box in the "Third Party Designee" area below. You will need to enter the designee's name, phone number, and any five numbers the designee chooses as his or her personal identification number (PIN). The PIN will be used to identify the designee if they contact the HCTC program.

Do you want to allow another person to discuss your HCTC account with the HCTC program?

☐ No.

☐ Yes. Complete the following:

Designee's Full Name (type or print legibly)	Telephone Number (Include area code)	Personal Identification Number (PIN)

Under penalties of perjury, I declare that the information furnished on this form with regard to myself and to any qualified family member(s), and any attachments to it, are true, correct, and complete. I understand that a knowing and willfully false statement on this form can result in my disqualification from participating in the advance tax credit program. By signing, I also agree to allow the IRS to share my eligibility status and payment information with my health plan administrator.

Signature (sign in black ink)	**Full Name (type or print legibly)**	**Date Signed**

Part IV: Qualified Family Members on Your Health Plan Policy

1. If you and your qualified family members are on the same health plan policy, list each qualified family member for whom you are seeking to claim the advance credit in the section below.

2. Photocopy this page if you need additional space.

   Note: Do not include qualified family members that have a qualified policy separate from yours. Fill out **Part V** of this form for those family members.

INFORMATION FOR QUALIFIED FAMILY MEMBER #1				
1. Last Name		2. First Name	3. Middle Name	4. Suffix (Jr., II)
5. SSN or TIN	6. Member ID	7. Date of Birth (mm/dd/yyyy)	8. Relationship ☐ Spouse ☐ Child ☐ Other	

INFORMATION FOR QUALIFIED FAMILY MEMBER #2				
1. Last Name		2. First Name	3. Middle Name	4. Suffix (Jr., II)
5. SSN or TIN	6. Member ID	7. Date of Birth (mm/dd/yyyy)	8. Relationship ☐ Spouse ☐ Child ☐ Other	

INFORMATION FOR QUALIFIED FAMILY MEMBER #3				
1. Last Name		2. First Name	3. Middle Name	4. Suffix (Jr., II)
5. SSN or TIN	6. Member ID	7. Date of Birth (mm/dd/yyyy)	8. Relationship ☐ Spouse ☐ Child ☐ Other	

INFORMATION FOR QUALIFIED FAMILY MEMBER #4				
1. Last Name		2. First Name	3. Middle Name	4. Suffix (Jr., II)
5. SSN or TIN	6. Member ID	7. Date of Birth (mm/dd/yyyy)	8. Relationship ☐ Spouse ☐ Child ☐ Other	

Part V: Qualified Family Members Listed on a Separate Qualified Policy

1. If any qualified family member has a health plan policy separate from yours, fill out this section for each of those family members.
2. You must include a copy of the current month's health plan invoice for each family member on a policy separate from yours.
3. You must complete the worksheet on this page to estimate the HCTC-eligible premium amount for each qualified family member on a health plan policy seperate from yours.
4. Photocopy this page if you need additional space.

INFORMATION FOR QUALIFIED FAMILY MEMBER #1			
1. Last Name	2. First Name	3. Middle Name	4. Suffix (Jr., II)
5. SSN or TIN	7. Date of Birth (mm/dd/yyyy)	8. Relationship ☐ Spouse ☐ Child ☐ Other	
9. Member ID	10. Group ID	11. Policy ID	
12. Policy Holder's Name (Last, First, Suffix)	13. Policy Holder's SSN or TIN		

Estimating the HCTC-Eligible Premium Amount for a Qualified Family Member Not on Your Policy

1. Use this worksheet to estimate the HCTC-eligible monthly premium amount for the qualified family member. You will need his or her most recent health plan invoice.
   - The family member's eligible premium amount does not include non-qualified family members.
   - The family member's eligible premium amount does not include exceptions (for example, vision and dental coverage).
   - The HCTC will pay for 65% of the actual eligible premium amount.

1. Enter the total health plan premium that your qualified family member pays per month. . . . . $ _____.____
2. Enter the total of any premiums paid per month for exceptions for this individual (for example, vision and dental coverage). . . . . $ _____.____
3. Subtract line 2 from line 1. This is the monthly estimated eligible premium amount for this individual. . . . . $ _____.____

Did You Remember To:

- ☐ Provide all the information for **Part I**?
- ☐ Answer all of the eligibility questions in **Part II**?
- ☐ Provide all of the information on your qualified health plan in **Part III**?
- ☐ Use the Estimating the HCTC-Eligible Premium Amount worksheet **on page 6** to calculate the estimated HCTC-eligible premium amount for you and any qualified family members who are on your policy?
- ☐ Fill out **Part IV** for any qualified family members who are on your policy?
- ☐ Fill out **Part V** if you are claiming any qualified family members and they have their own policy?
- ☐ Use the Estimating the HCTC-Eligible Premium Amount worksheet **on page 8** to calculate the estimated HCTC-eligible premium amount for any qualified family members who have their own policy?
- ☐ Sign and date the HCTC Registration Form **on page 6**?
- ☐ Include the necessary health plan verification documents for you and any qualified family members in the envelope provided?
- ☐ Keep a copy of your completed HCTC Registration Form and any required documents for your personal records?
- ☐ Put your SSN or TIN on the bottom of each page of this Registration Form where indicated?

Mailing Address:

Mail your complete HCTC Registration Form and all required documents in the enclosed postage paid envelope.

Or, mail it to:

HCTC Processing Center
P.O. Box 4700
Waterloo, IA 50701

When you submit the completed Registration Form:

Attach a copy of the current month's health plan invoice(s) for you and any qualified family members to this page,

AND

If you have COBRA, also attach a copy of your COBRA election letter.

IMPORTANT

You must pay your health plan invoice in full for each period you are not invoiced by HCTC.

Department of the Treasury
Internal Revenue Service

www.irs.gov

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