

49 2007

Summary of Comments on Health Coverage Tax Credit Registration Form

Page: 2

Author: Tracy M. Delaney
Subject: Cross-COA
Date: 5/18/2005 4:02:37 PM

Author: Tracy M. Delaney
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
File: P

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 when 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 pay certain types of health coverage during the tax year. Section 527 lets you authorize your health coverage provider to receive this credit in advance in the form of monthly payments from the Internal Revenue Service.

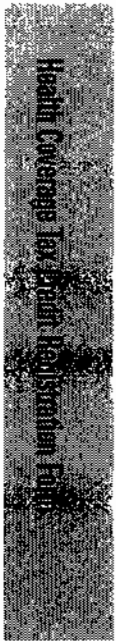
The information you submit is used to determine if you qualify for the advance payment of the Health Coverage Tax Credit (HCTC). If you fail to provide the information, or provide inaccurate information, your application may be denied. However, you may still qualify for the HCTC when you file your federal 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 also 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 tax administration purposes. We may also disclose the 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 1-866-628-HCTC (1-866-628-4282).

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 95743-0801. DO NOT send the form to this office.



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

OMB No. 1545-1947

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 invoices for you and any qualified family members and, if applicable, COBRA election letters.

Periston Benefit Guaranty Corporation (PBGC) Recipients Only: If you currently receive benefits from the PBGC as a survivor, a beneficiary, or an alternate payee under a qualified domestic relation, order and you are at least 55 years old, you are considered to be the HCTC candidate. You should read and answer the questions on this Registration Form from this point of view.

Instructions:

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

1 SSN or TIN		7 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
11 Telephone Number (include area code and extension)		12 Preferred Language for Mailing (mark only one of the following)	
Primary <input type="checkbox"/> Alternate <input type="checkbox"/>		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> English - Large Print <input type="checkbox"/> Spanish - Large Print <input type="checkbox"/> Braille	
10 Zip Code			

Page: 3

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
For the advance HCTC Program

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM

Author: Treoy M Delaney
Subject: Inserted Text
Date: 5/16/2005 4:02:37 PM

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Refer to question number 3 on page 157 of the HCTC Program Kit for more information)

Author: shawn.m.burns
Subject: Cross-Out
Date: 5/19/2005 4:02:37 PM
Delete all text and check boxes

Author: shawn.m.burns
Subject: Cross-Out
Date: 5/19/2005 4:02:37 PM



Part II: Complete This Part to Determine Your Eligibility

1. Are you any of the following: (Check the box next to all that apply)

- Receiving a Trade Readjustment Allowance (TRA) under the Trade Adjustment Assistance (TAA) program or would be receiving a TRA except that you have not used up your unemployment insurance (UI) benefits.
- Receiving a pension benefit from the Pension Benefit Guaranty Corporation (PBGC) and are at least 55 years old.
- Receiving benefits under the Alternative Trade Adjustment Assistance (ATAA) program.

If you only checked the ATAA box, you must call the HCTC Customer Contact Center before filling out this form.

Did you check any of the boxes above?
No. Stop; you are not eligible to register for the advance tax credit at this time.
Yes. Go to question 2.

2. Are you currently any of the following: (Check the box next to any that apply)

- Enrolled in a health plan maintained by an employer or former employer that pays at least 50% of the cost of coverage (This includes any amount contributed on a pre-tax basis)
- Enrolled in 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)
- Enrolled in a health plan maintained by your spouse, employer or former employer that pays at least 50% of the cost of coverage (This includes any amount contributed on a pre-tax basis)

Did you check any of the boxes above?
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 federal tax return this year?
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?
See Step 2 in the HCTC Program for the definition of 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. If the health plan is COBRA continuation coverage, go to question 7. Otherwise, stop. You are not eligible for the advance payment option. If the employer pays for less than 50% of the cost of coverage, you may be able to claim the credit when you file your federal tax return.

Page: 4

Author: shawn.m.burns
Subject: Cross-Out
Date: 5/19/2005 4:02:37 PM
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Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
✚

Author: shawn.m.burns
Subject: Cross-Out
Date: 5/19/2005 4:02:37 PM
✘

Author: shawn.m.burns
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Date: 5/19/2005 4:02:37 PM
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Author: shawn.m.burns
Subject: Cross-Out
Date: 5/19/2005 4:02:37 PM
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Author: shawn.m.burns
Subject: Cross-Out
Date: 5/19/2005 4:02:37 PM
✘

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
✚

Part II: Complete This Part to Determine Your Eligibility

1. Are you any of the following: (Check the box next to all that apply)

- Receiving a Trade Readjustment Allowance (TRA) under the Trade Adjustment Assistance (TAA) program or would be receiving a TRA except that you have not used up your unemployment insurance (UI) benefits
 - Receiving a pension benefit from the Pension Benefit Guaranty Corporation (PBGC) and are at least 55 years old
 - Receiving benefits under the Alternative Trade Adjustment Assistance (ATAA) program
- If you only checked the ATAA box, you must call the HCTC Customer Contact Center before filling out this form.**

Did you check any of the boxes above?

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: (Check the box next to any that apply)

- Enrolled in a health plan maintained by an employer or former employer that pays at least 50% of the cost of coverage. (This includes any amount contributed on a pre-tax basis.)
- Enrolled in 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)
- Enrolled to health coverage through the U.S. military health system (TRICARE/CHAMPUS)
- Enrolled in a health plan maintained by your spouse's employer or former employer that pays at least 50% of the cost of coverage. (This includes any amount contributed on a pre-tax basis.)

Did you check any of the boxes above?

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 federal tax return this year?

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?

See Step 2 in the HCTC Program Kit for the definition of a qualified health plan.

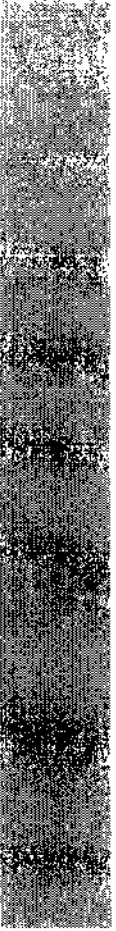
No. Stop, you are not eligible to register for the advance tax credit at this time.

Yes. Go to question 6.

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

No. Go to question 7.

Yes. If the health plan is COBRA continuation coverage, go to question 7. Otherwise, **stop**. You are not eligible for the advance payment option. If the employer pays for less than 50% of the cost of coverage, you may be able to claim the credit when you file your federal tax return.



Subject: Inherited Tax
Date: 5/19/2005 4:02:37 PM
Do not send this registration form. Y

Author: shawn.m.burns
Subject: Comment on Text
Date: 5/19/2005 4:02:37 PM
Underline or bold to emphasize



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 (This includes your or your spouse's COBRA coverage.)
 HCTC state-qualified health plan
 Individual coverage in which you were enrolled for at least 30 days prior to separation from the job that made you TAA 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 9-11 and go to **Part III** on **page 5**.
 Yes. Go to question 9.

9. Answer this question for each family member for whom you wish to claim the credit. ~~After answering this question for all of these family members, follow the instructions below.~~
 Is the family member:
 Enrolled in a health plan maintained by the family member's employer or former employer that pays at least 50% of the cost of coverage (This includes any amount contributed on a pre-tax basis.)
 Enrolled 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)
 Enrolled to health coverage through the U.S. military health system (TRICARE/CHAMPUS)

If you answered yes to any part of question 9 for any 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.

If you answered no to ALL parts of question 9 for any family members, go to question 10 for those family members

10. Are all of your qualified family members covered by qualified health plans?
 See Step 2 in the HCTC Program Kit for the definition of a qualified health plan
 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**

11. Are all of your qualified family members covered on your health plan policy?
 No. Complete **Part III** on **page 5** to provide information about your qualified health plan. Read the instructions at the bottom of **page 5** on how to report family members who have their own qualified health plan policy.

Yes. Complete **Part III** on **page 5** to provide information about your qualified health plan. Read the instructions at the bottom of **page 5** on how to report family members who are on your health plan policy.

Author: shawni.m.burns
 Subject: Note
 Date: 5/19/2005 4:02:37 PM
 Order:
 1 COBRA
 2 Non-group
 3 State-qualified

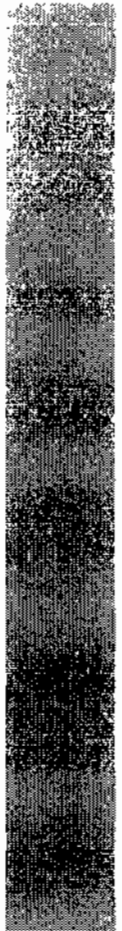
Author: shawni.m.burns
 Subject: Cross-Out
 Date: 5/19/2005 4:02:37 PM

Author: shawni.m.burns
 Subject: Inserted Text
 Date: 5/19/2005 4:02:37 PM
 Non-group (individual) coverage that began at least 30 days prior to separation from the employment that made you TAA, ATAA or PBGC eligible

Author: shawni.m.burns
 Subject: Cross-Out
 Date: 5/19/2005 4:02:37 PM

Author: shawni.m.burns
 Subject: Inserted Text
 Date: 5/19/2005 4:02:37 PM
 Continue as instructed below

Author: shawni.m.burns
 Subject: Inserted Text
 Date: 5/19/2005 4:02:37 PM
 Even if they are not enrolled or receiving the benefit)



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

1. Complete this section and the worksheet on page 6 to provide information about your qualified health plan

1 Member ID	2 Group ID	3 Policy ID
4 Policy Holder's Name (Last, First, Suffix)	5 Policy Holder's SSN or TIN	
6 Total Number of People Both Qualified and Non-Qualified on This Health Plan Policy		7 Number of Non-Qualified People on This Health Plan Policy

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

1 Former Employer's Name	2 Former Employer's Telephone Number (include area code)
--------------------------	--

2. You must also include proof of insurance for each qualified health plan policy when you submit this form.

- COBRA - include a copy of the COBRA election letter and a copy of the current month's health plan invoice.
- HCTC state-qualified or qualified individual coverage - include a copy of the current month's health plan invoice

The HCTC program will use these documents to verify the health plan information provided, to determine the HCTC-eligible premium amount and to calculate your monthly payment responsibility for the policy.

Any health plan invoice sent must list as a separate line item any premium amounts paid for:

- Non-qualified family members on the health plan policy
 - Exceptions on the health plan policy
- See Step 4 in the HCTC Program Kit for the definition of exceptions.

If the invoice does not meet the two criteria above, you must provide a letter from the health plan administrator that lists the amounts paid for non-qualified family members and for exceptions as separate line items from the major medical expenses/premiums on the policy

Complete the worksheet on page 6 and sign and date the form. In addition:

- If you do not have any family members who are eligible for the credit, turn to page 10 for details on how to submit your completed Registration Form.
- If you have qualified family members for whom you wish to claim the advance credit and they are on your health plan policy, complete Part IV on page 7.
- If you have qualified family members for whom you wish to claim the advance credit and they have their own qualified health plan policy, complete Part V on page 8.

Page: 6

Author: Tracy M Delaney
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Page: 5/19/2005 4:02:37 PM

Author: Tracy M Delaney
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
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Author: Tracy M Delaney
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Page: 5/19/2005 4:02:37 PM

Author: Tracy M Delaney
Subject: Note
Date: 5/19/2005 4:02:37 PM
Page: 5/19/2005 4:02:37 PM
* Above if your qualified health plan is COBRA... Insert * You must complete at least one of fields in order for your HCTC Registration Form to be processed

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Page: 5/19/2005 4:02:37 PM
* Insert COBRA

Author: Tracy M Delaney
Subject: Note
Date: 5/19/2005 4:02:37 PM
Page: 5/19/2005 4:02:37 PM
* Insert New Box Below: Start Date for COBRA Coverage

Author: Tracy M Delaney
Subject: Note
Date: 5/19/2005 4:02:37 PM
Page: 5/19/2005 4:02:37 PM
* Insert New Box Below: End Date for COBRA Coverage
Add a half divider (like in #7 above) with a check box and title "Mark if lifetime benefit"

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Page: 5/19/2005 4:02:37 PM
* Also include a copy of your current invoice from your health plan

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Page: 5/19/2005 4:02:37 PM
* Also include a copy of your current invoice from your health plan

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Page: 5/19/2005 4:02:37 PM
* Also include a copy of your current invoice from your health plan

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Page: 5/19/2005 4:02:37 PM
* Also include a copy of your current invoice from your health plan

Comments from page 6 continued on next page

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

1. Complete this section and the worksheet on page 6 to provide information about your qualified health plan

1 Member ID	2 Group ID	3 Policy ID
4 Policy Holder's Name (Last, First, Suffix)	5 Policy Holder's SSN or TIN	
6 Total Number of People Both Qualified and Non-Qualified on This Health Plan Policy	7 Number of Non-Qualified People on This Health Plan Policy	

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

1 Former Employer's Name	2 Former Employer's Telephone Number (include area code)
--------------------------	--

2. You must also include proof of insuranc... for each qualified health plan policy when you submit this form:

- COBRA - Include a copy of the COBRA election letter and a copy of the current month's health plan invoice
- HCTC state-qualified or qualified individual coverage - include a copy of the current month's health plan invoice

The HCTC program will use these documents to verify the health plan information provided, to determine the HCTC-eligible premium amount and to calculate your monthly payment responsibility for the policy.

Any health plan invoice sent must list as a separate line item any premium amounts paid for:

- Non-qualified family members on the health plan policy
- Exceptions on the health plan policy

If the invoice does not meet the two criteria above, you must provide a letter from the health plan administrator that lists the amounts paid for non-qualified family members and for exceptions as separate line items from the major medical expenses/premiums on the policy.

Complete the worksheet on page 6 and sign and date the form. In addition:

- If you do not have any family members who are eligible for the credit, turn to page 10 for details on how to submit your completed Registration Form.
- If you have qualified family members for whom you wish to claim the advance credit and they are on your health plan policy, complete Part IV on page 7.
- If you have qualified family members for whom you wish to claim the advance credit and they have their own qualified health plan policy, complete Part V on page 8.

✉

Author: shawn m burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Type: Non-group (Individual)

✉
Author: shawn m burns
Subject: Cross-Dir
Date: 5/19/2005 4:02:37 PM

✉
Author: shawn m burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM

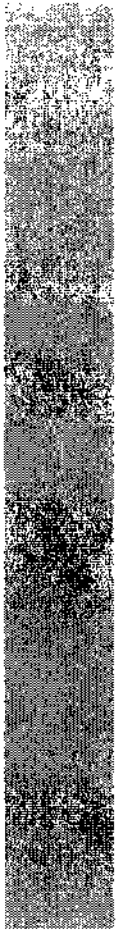
✉
Author: shawn m burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Type: If you do not have the documents listed above as proof of insurance, refer to Step 3 in the Program Kit

✉
Author: shawn m burns
Subject: Comment on Text
Date: 5/19/2005 4:02:37 PM
Type: un-bidd statement

✉
Author: shawn m burns
Subject: Cross-Dir
Date: 5/19/2005 4:02:37 PM

✉
Author: shawn m burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Type: 2

✉
Author: shawn m burns
Subject: Comment on Text
Date: 5/19/2005 4:02:37 PM
Type: underline



Estimate the Payment Responsibility for You and All Qualified Family Members on Your Health Plan Policy

1. Use this worksheet to provide the HCTC program an estimate of your HCTC-eligible monthly premium amount and your estimated monthly payment responsibility for this health plan policy.

Please note: The actual amounts will be calculated using the health plan invoice you provide.

- 1 Enter the total monthly premium paid for the health plan policy (1) \$
- 2 Enter the total monthly premium paid for non-qualified family members on your policy (2) \$
- 3 Enter the total of monthly premiums paid for exceptions on this policy (for example, vision and dental coverage) (3) \$
- 4 Enter the amount of your monthly premium that you pay using funds from an Archer MSA (Medical Savings Account) (4) \$
- 5 Add lines 2, 3 and 4. Enter the result here. This is the estimated total monthly ineligible premium amount (5) \$
- 6 Subtract line 5 from line 1 and enter the result here. This is the estimated monthly HCTC-eligible premium amount. (6) \$
- 7 Multiply line 6 by 35% (.35) and enter the result here. (7) \$
- 8 Add lines 5 and 7. This is an estimate of your total monthly payment responsibility for this policy (8) \$

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

If you want a ~~partner~~ friend, family member, or any other person you choose to discuss your HCTC account with, the HCTC program needs the "Third Party Designee" area below. You will need to enter the designee's name, phone number, and any line 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 members, and any attachments to this form, correct and complete. I understand that a knowingly and willfully false statement on this form can result in my disqualification from participating in the advance funding 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

Page: 7

Author: shawn m burns
Subject: Cross-Cut
Date: 5/19/2005 4:02:37 PM

Author: shawn m burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Use this worksheet to estimate your eligible monthly premium amount and monthly payment responsibility for this health plan policy. The actual amounts will be calculated by the HCTC Program using the health plan invoice you provide.

Author: shawn m burns
Subject: Cross-Cut
Date: 5/19/2005 4:02:37 PM

Author: shawn m burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
2. Refer to the Step 1 and 2 in the HCTC Program Kit for more information about qualified family members and exceptions.

Author: shawn m burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
an HSA (Health Savings Account), or both.

Author: shawn m burns
Subject: Note
Date: 5/19/2005 4:02:37 PM
Move signature box to this location, or above the TPID box.

Author: shawn m burns
Subject: Cross-Cut
Date: 5/19/2005 4:02:37 PM

Author: shawn m burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM

Author: shawn m burns
Subject: Cross-Cut
Date: 5/19/2005 4:02:37 PM

Author: shawn m burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM

Author: shawn m burns
Subject: Cross-Cut
Date: 5/19/2005 4:02:37 PM

Author: Shawn M Burns
 Subject: Inland Tax
 Date: 5/19/2015 4:02:37 PM

Estimate the Payment Responsibility for You and All Qualified Family Members on Your Health Plan Policy

- Use this worksheet to provide the HCTC program an estimate of your HCTC-eligible monthly premium amount and your estimated monthly payment responsibility for this health plan policy.

Please note: The actual amounts will be calculated using the health plan invoice your provider.

1. Enter the total monthly premium paid for the health plan policy for non-qualified family members on your policy:	(1) \$
2. Enter the total monthly premium paid for exceptions on this policy (for example, vision and dental coverage):	(2) \$
3. Enter the amount of your monthly premium that you pay using funds from an Archer MSA (Medical Savings Account):	(3) \$
4. Add lines 2, 3 and 4. Enter the result here. This is the estimated total monthly ineligible premium amount:	(4) \$
5. Subtract line 5 from line 1 and enter the result here. This is the estimated monthly HCTC-eligible premium amount:	(5) \$
6. Multiply line 6 by 35% (.35) and enter the result here:	(6) \$
7. Add lines 5 and 7. This is an estimate of your total monthly payment responsibility for this policy:	(7) \$
8. Add lines 5 and 7. This is an estimate of your total monthly payment responsibility for this policy:	(8) \$



Third Party Designer
 A third party designer 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 Designer" area below. You will need to enter the designer's name, phone number, and any five numbers the designer chooses as his or her personal identification number (PIN). The PIN will be used to identify the designer if they contact the HCTC program.

Do you want to allow another person to discuss your HCTC account with the HCTC program?
 Yes No

Complete the following:

Designer's Full Name (Type or print legibly)	Telephone Number (include area code)	Personal Identification Number (PIN)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Under penalty of perjury, I declare that the information furnished on this form was true and correct, and that I am not providing any false or misleading information. I understand that any false or misleading information provided on this form may result in my disqualification from participating in the advance notice program. By signing this form, I am agreeing 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 V: Complete This Part to Provide Information About Qualified Family Members Listed on a Separate Qualified Policy

1. Complete this section and the worksheet on page 9 to provide information about qualified family members with their own qualified health plan policy.
2. Photocopy this page before filling it out if you have more family members than the space below allows.
3. You must also include proof of insurance for each qualified health plan policy you are trying to claim when you submit this form. See page 5 for instructions on what required documents you must submit.

1. SSN or TIN	2. Date of Birth (mm/dd/yyyy)	3. Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
4. Last Name	5. First Name	6. Middle Name
		7. Suffix (if any)

1. Member ID	2. Group ID	3. Policy ID
4. Policy Holder's Name (Last, First, Suffix)	5. Policy Holder's SSN or TIN	
6. Total Number of People Both Qualified and Non-Qualified on This Health Plan Policy	7. Number of Non-Qualified People on This Health Plan Policy	

What type of qualified health plan policy does this family member have?

- COBRA continuation coverage where the employer/former employer pays less than 50% of the cost of coverage
- HCTC state-qualified health plan
- Other qualified individual coverage

If the family member's qualified health plan is COBRA, you must also provide the following information:

1. Former Employer's Name	2. Former Employer's Telephone Number (include area code)
---------------------------	---

* 9 Complete the worksheet on page 9 to provide the HCTC registration as a wage-earner HCTC coverage monthly premium amount and your estimated monthly payment responsibility for this family member's health plan policy.

Author: Tracy M. Delaney
 Subject: Inserted Text
 Date: 5/19/2005 4:02:37 PM
 If you do not have any qualified family members do not complete this section

Author: Tracy M. Delaney
 Subject: Inserted Text
 Date: 5/19/2005 4:02:37 PM

Author: Tracy M. Delaney
 Subject: Inserted Text
 Date: 5/19/2005 4:02:37 PM

Author: Tracy M. Delaney
 Subject: Inserted Text
 Date: 5/19/2005 4:02:37 PM

Author: Tracy M. Delaney
 Subject: Note
 Date: 5/19/2005 4:02:37 PM
 (same as on page 6) You must complete at least one of these fields in order for your HCTC Registration Form to be processed

Author: shawn m burns
 Subject: Note
 Date: 5/19/2005 4:02:37 PM
 Re-order (same as pg 5)
 1. Cobra
 2. Non-group
 3. State-qualified

Author: shawn m burns
 Subject: Cross-Out
 Date: 5/19/2005 4:02:37 PM

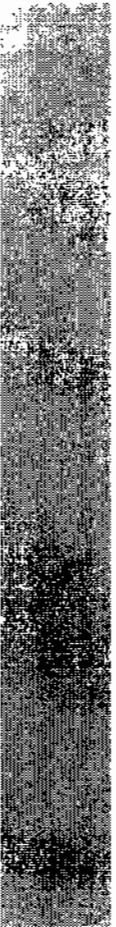
Author: shawn m burns
 Subject: Inserted Text
 Date: 5/19/2005 4:02:37 PM
 (non-group individual)

Author: shawn m burns
 Subject: Note
 Date: 5/19/2005 4:02:37 PM
 Insert Former Employer and COBRA box from page 6 Center in line with this bullet

Author: shawn m burns
 Subject: Cross-Out
 Date: 5/19/2005 4:02:37 PM

Author: shawn m burns
 Subject: Inserted Text
 Date: 5/19/2005 4:02:37 PM

Comments from page 9 continued on next page



Top

Part V: Complete This Part to Provide Information About Qualified Family Members Listed on a Separate Qualified Policy

1. Complete this section and the worksheet on page 9 to provide information about qualified family members with their own qualified health plan policy.
2. Photocopy this page before filling it out. If you have more family members than the space below allows.
3. You must also include proof of insurance for each qualified health plan policy you are trying to claim when you submit this form. See page 5 for instructions on what required documents you must submit.

1. SSN or TIN	2. Date of Birth (mm/dd/yyyy)	3. Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
4. Last Name	5. First Name	6. Middle Name
		7. Suffix (if any)

1. Member ID	2. Group ID	3. Policy ID
4. Policy Holder's Name (Last, First, Suffix)	5. Policy Holder's SSN or TIN	
6. Total Number of People Both Qualified and Non-Qualified on This Health Plan Policy	7. Number of Non-Qualified People on This Health Plan Policy	

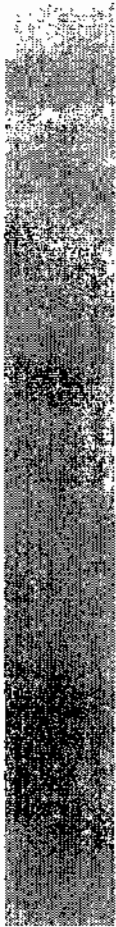
What type of qualified health plan policy does this family member have?

- COBRA continuation coverage where the employer/former employer pays less than 50% of the cost of coverage
- HCTC state-qualified health plan
- Other qualified individual coverage

If the family member's qualified health plan is COBRA, you must also provide the following information:

1. Former Employer's Name	2. Former Employer's Telephone Number (include area code)
---------------------------	---

Complete the worksheet on page 9 to provide the HCTC program an estimate of the HCTC-eligible monthly premium amount and your estimated monthly payment responsibility for this family member's health plan policy.



Estimate the Payment Responsibility for Your Qualified Family Member's Health Plan Policy

1. Use this worksheet to provide the HCTC program an estimate of the HCTC-eligible monthly premium amount and your estimated monthly payment responsibility for the health plan policy.

Please note: The actual amounts will be calculated using the health plan invoice your provider.

1. Enter the total monthly premium paid for the health plan policy: (1) \$ _____
2. Enter the total monthly premium paid for non-qualified family members on this policy: (2) \$ _____
3. Enter the total of monthly premiums paid for exceptions on this policy (for example, vision and dental coverage): (3) \$ _____
4. Enter the amount of the monthly premium for this policy that is paid using funds from an Archer MSA (Medical Savings Account): (4) \$ _____
5. Add lines 2, 3 and 4. Enter the result here. This is the estimated total monthly **ineligible** premium amount: (5) \$ _____
6. Subtract line 5 from line 1 and enter the result here. This is the estimated monthly **HCTC-eligible** premium amount: (6) \$ _____
7. Multiply line 6 by 35% (.35) and enter the result here: (7) \$ _____
8. Add lines 5 and 7. This is an estimate of your **total** monthly payment responsibility for this policy: (8) \$ _____

Turn to page 10 for details on how to submit your completed Registration Form.

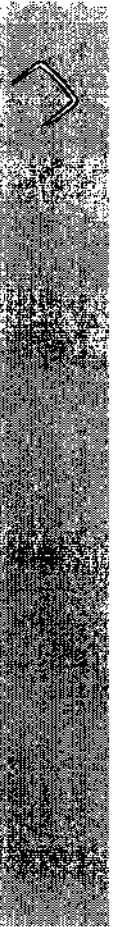
Page: 10

Author: Shawn m burns
Subject: Cross-Cut
Date: 5/19/2005 4:02:37 PM

Author: Shawn m burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM

1. Use this worksheet to estimate your eligible monthly premium amount and monthly payment responsibility for this health plan policy. The actual amounts will be calculated by the HCTC Program using the health plan invoice your provider.

2. Refer to the Step 1 and 2 in the HCTC Program Kit for more information about qualified family members and exceptions.



Attach to This Page:

A copy of the current month's health plan invoice(s) for you and any qualified family members and
If you or your qualified family members have COBRA, also attach
a copy of the COBRA election letter(s).

Before You Mail the Registration Form, Did You Remember To:

1. Complete all required sections of the Registration Form?
2. Sign and date the Registration Form on page 6?
3. Put your SSN or TIN at the bottom of each page of this Registration Form where indicated.
4. Attach all necessary health plan verification documents to this page for you and your qualified family members.
5. Keep a copy of your completed HCTC Registration Form and any required documents for your personal records?

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
Watertown, IA 50701

Please note, the registration process typically takes 4 to 6 weeks to complete. You should continue to pay 100% of your health plan premium directly to your health plan administrator until you receive confirmation from the HCTC that you have been re-enrolled for the advance payment option of the HCTC.

Thank you for completing the HCTC Registration Form!

Need Assistance?

Call toll-free 1-866-628-HCTC (1-866-628-4282)
TDD/TTY callers, please call 1-866-626-HCTC (1-866-626-4282)
Or visit us on the Web at <http://www.irs.gov> (IRS keyword: HCTC).

Page: 11

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Including a copy of your COBRA election letter (if applicable)

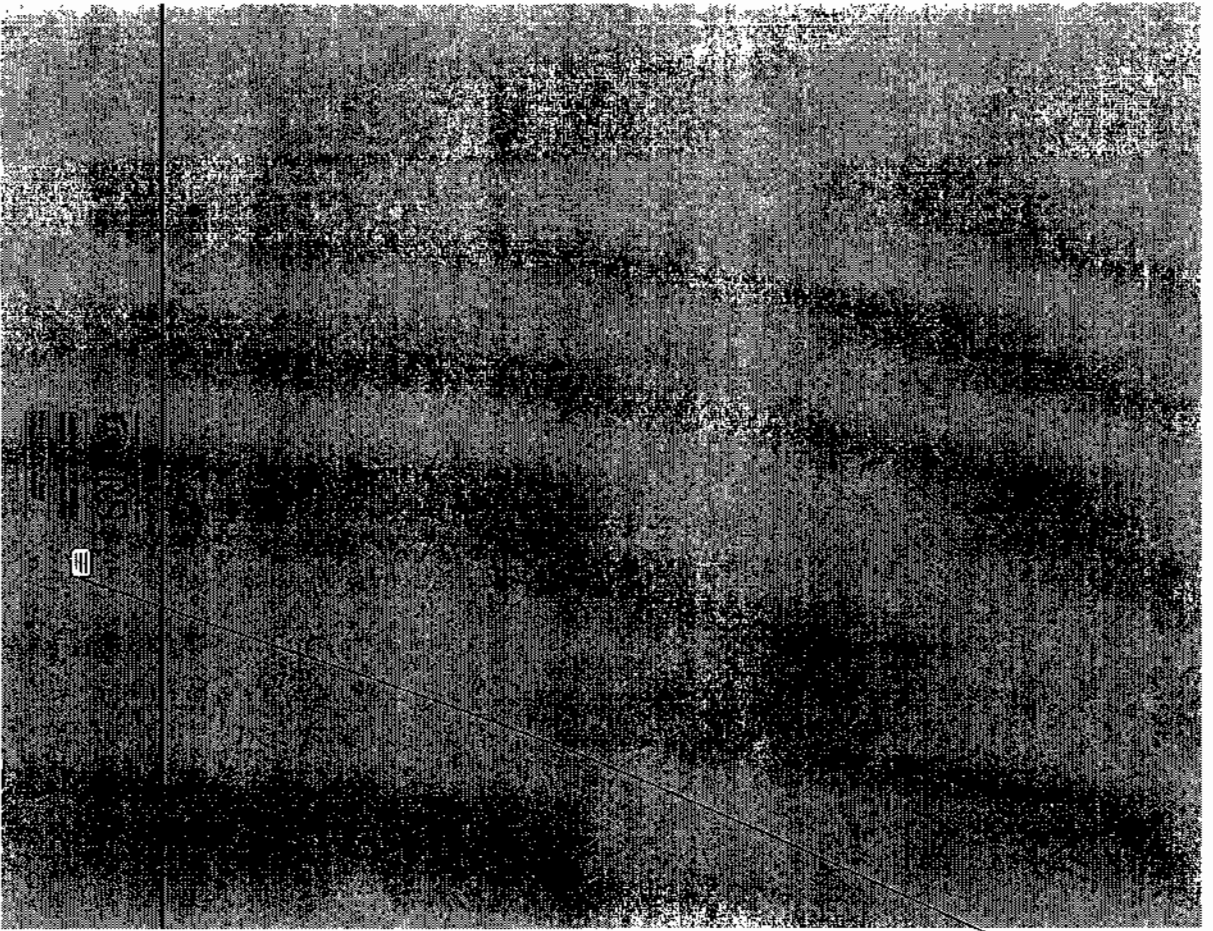
Author: shawn.m.burns
Subject: Cross-Out
Date: 5/19/2005 4:02:37 PM

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM
Visit us on the Web at www.irs.gov (IRS keyword: HCTC)

Author: shawn.m.burns
Subject: Inserted Text
Date: 5/19/2005 4:02:37 PM

Author: shawn.m.burns
Subject: Comment on Text
Date: 5/19/2005 4:02:37 PM
I think I'm

Author: shawn.m.burns
Subject: Cross-Out
Date: 5/19/2005 4:02:37 PM

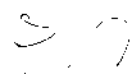


Page: 12

Author: Tracy, M. Deaney
Subject: None
Date: 5/19/2005 4:02:37 PM
Update Revision Date

Registration Form

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 tax administration 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.