Form **13704** (Rev. October 2007)	Department of the Treasury–**Internal Revenue Service** **MONTHLY HCTC REGISTRATION UPDATE FORM**	**OMB Number 1545-1954**

Use this form to make updates to your monthly Health Coverage Tax Credit (HCTC) account. When you are enrolled in the monthly HCTC Program, you must inform us of all changes that affect your eligibility, your family members and your health insurance. If you do not keep your HCTC account information current, you could risk losing the monthly HCTC.

Instructions:

1. **Keep a blank copy** of this form in your personal records for future use. This form can also be found at www.irs.gov (Keyword/Search: HCTC).
2. Only use this form if you need to make **changes** to your HCTC account.
3. **Print or type** your responses. Leave blank any box that does not apply to you or your family members.
4. Part V, Provide information about your qualified health insurance, is required.
5. You must sign and date this form to confirm your continued eligibility for the HCTC.
6. Keep a copy of this completed Registration Update Form and all required supporting documents for your personal records.
7. **DO NOT SEND PAYMENT WITH THIS FORM.** Mail the completed form and required supporting documents to:
   HCTC Processing Center
   P.O. Box 4700
   Waterloo, IA 50704-9925

If you have any questions about this form, please contact the HCTC Customer Contact Center toll-free at 1-866-628-HCTC (4282).
If you have a hearing impairment, call 1-866-626-4282 (TTY).

Part I: Provide information about you

Your name *(first, middle initial, last, suffix)*

Your mailing address *(street number)*	*(city, state, ZIP)*
Social security number	Date of birth *(mm/dd/yyyy)*
Primary telephone number *(include area code)*	Check here if address or phone has changed ☐

Note: You must also provide mailing address changes to the agency that reports you as eligible for the HCTC Program. This is either your state (unemployment office) or the Pension Benefit Guaranty Corporation (PBGC).

Part II: Confirm your eligibility

Confirm that the following statements are true. Check the boxes that apply. I certify that:

- ☐ I am an eligible Trade Adjustment Assistance (TAA) or Alternative TAA recipient, **or** I am a Pension Benefit Guaranty Corporation (PBGC) pension recipient and at least 55 years of age.
- ☐ I have qualified health insurance.
- ☐ I am not covered by any health insurance plan where my former employer, or spouse's employer, pays 50% or more of the premiums.
- ☐ I cannot receive Medicare benefits or health coverage through the U.S. military health system (CHAMPUS/TRICARE).
- ☐ I am not enrolled in Medicaid, the State Children's Health Insurance Program (SCHIP), or the Federal Employees Health Benefits Program (FEHBP).
- ☐ No one can claim me as a dependent on his or her tax return.
- ☐ I am not in prison.

If you did not certify all statements above, you are no longer eligible to receive the HCTC. STOP! Do not submit this form. Instead, call the HCTC Customer Contact Center to tell us about this change.

Part III: Tell us what to change on your HCTC account

Check all that apply	Effective date of change *(mm/dd/yyyy)*
☐ Add or remove a family member.	
☐ Change information about *current* health insurance (e.g., change in premium amount, change in any ID numbers, change in address where payments are currently sent).	
☐ The administrator for my COBRA coverage has changed (COBRA only).	
☐ I have *new* HCTC qualified health insurance.	
☐ Switch my eligibility type from TAA/ATAA to PBGC. **To switch your eligibility type from TAA to ATAA, call the HCTC Customer Contact Center.**	
☐ Check this box to reactivate your HCTC account if you were enrolled within the last 90 days.	

Part III (Continued)

Reason for update

Part IV: Provide information about a family member

Add eligible family member ☐
Remove ineligible family member ☐

Make a copy of this page before filling it out if you have more family members than the space allows.

Family member's name *(first, middle initial, last, suffix)*

Social security number	Date of birth *(mm/dd/yyyy)*

Is this person on your health plan?

☐ **Yes** ☐ **No** He or she has a separate plan from me (use Part V to give this health insurance information, as applicable).

Relationship to you ☐ **Spouse** ☐ **Child** ☐ **Other**

Part V: Provide information about your qualified health insurance

Part V is required. You must submit proof of insurance (ex. a current bill) and any other required documentation for the health insurance policy you describe below. See page 8 of the Registration Form or the website www.irs.gov (Keyword/Search: HCTC) for detailed information on the required supporting documents you must submit.

Please complete this section.

Name of health plan		Type of coverage: ☐ COBRA ☐ State-qualified ☐ Non-group/individual	
Health plan ID number	Member ID	Group ID	Policy or Plan ID

Note: *You must fill out at least one ID for your account update to be considered complete.*

Policyholder's name *(first, middle initial, last, suffix)*

Policyholder's social security number	Total monthly premium

Total number of people (you and any family members) on this policy	
Number of family members on this policy who are not eligible for the HCTC	
Monthly premium amount for family members who are not eligible for the HCTC	
Extra monthly premium amount that covers dental or vision plans	

Complete this section only if you have COBRA coverage.

Your former employer	Former employer's telephone number *(include area code)*
Start date for COBRA coverage *(mm/dd/yyyy)*	End date for COBRA coverage *(mm/dd/yyyy)* *Check here if Lifetime Benefit* ☐

Complete this section only if you have non-group/individual coverage.

Employer that made you eligible for PBGC or TAA benefits	Employer's telephone number *(include area code)*
Your last paid day of work for that employer	Start date of non-group/individual insurance

Part VI: Sign and date this form to confirm your HCTC eligibility

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

Signature	Full Name (print)	Date

PAPERWORK REDUCTION ACT NOTICE. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Your response is voluntary. 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 become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by code section 6103. The estimated average time to complete this form is 15 minutes. If you have comments concerning the accuracy of this time estimate or suggestions for making this form simpler, we will be happy to hear from you. You can write to the Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, Washington, DC 20224.

PRIVACY ACT STATEMENT. The following information is provided to comply with the Privacy Act of 1974 (P.L.93-579). All information collected on this form is required under the provisions of 31 U.S.C. 3322 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data, by electronic means to vendor's financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the Automated Clearing House Payment System.