The Health Coverage Tax Credit (HCTC) Reimbursement Request Form

Use this form to request an HCTC reimbursement credit for premiums you paid directly to a qualified health plan while you were eligible and enrolling in the monthly HCTC Program. You must be a Monthly HCTC Participant or have an HCTC registration in process for your request to be considered.

Instructions:

1. Print or type your responses. Leave blank any box that does not apply to you or your family members.
2. Determine if you are eligible and request an HCTC reimbursement in Part 2.
3. Complete information about your qualified health insurance, as ***required*** in Part 3.
4. Provide verifiable proof that your health plan is qualified and that you paid the qualified health insurance premiums by attaching the required supporting documents to your Reimbursement Request Form.
5. Mail the completed form and required supporting documents to:

   HCTC Processing Center
   P.O. Box 4700
   Waterloo, IA 50704-9925
6. **NEXT:** If your request is approved, reimbursement will be posted as a credit on your monthly HCTC account and HCTC invoice. If your request is not approved, the HCTC Program will send a letter that explains why your request was denied.

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.

Part 1: Provide information about you

Your name (first, middle initial, last, suffix)	Social Security Number
Your mailing address (street address)	(city, state, zip)

Telephone Number:

Part 2: Complete this part to see if you are eligible to receive this reimbursement

Complete this section to request reimbursement for payments you made while enrolling in the HCTC Program. Only months that occur on or after the date printed on your original HCTC Eligibility Certificate can be reimbursed. Any other eligible months must be claimed when you file your federal tax return, on IRS Form 8885. (***Note: Your HCTC Eligibility Certificate is the letter you received with your original HCTC Program Kit and Registration Form***).

Check the boxes below for each month during this calendar in which you are requesting reimbursement ***and*** all of the following statements are true on the first day of that month.

- You were an eligible Trade Adjustment Assistance (TAA), Alternative TAA (ATAA), or Reemployment TAA (RTAA) recipient, or a Pension Benefit Guaranty Corporation (PBGC) recipient.
- You were covered by a qualified health insurance plan for which you paid the premiums, or your portion of the premiums, directly to your health plan.
- You were ***not*** entitled to Medicare Part A or enrolled in Medicare Part B.
- You were ***not*** enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP).
- You were ***not*** enrolled in the Federal Employees Health Benefits Program (FEHBP) or eligible to receive benefits under the U.S. military health system (TRICARE).
- You were ***not*** imprisoned under federal, state, or local authority.
- You did ***not*** receive a 65% COBRA Premium Reduction (*For more information on the COBRA Premium Reduction, please visit: www.dol.gov/COBRA)*

☐ January	☐ February	☐ March	☐ April	☐ May	☐ June
☐ July	☐ August	☐ September	☐ October	☐ November	☐ December

Enter the **TOTALS** for **ALL MONTHS** checked above.

1	Enter the **total** amount you paid directly to your qualified health plan.		
2	Enter the **total** amount you paid for dental or vision benefits. These benefits do not qualify for the HCTC.		
3	**Subtract line 2 from line 1. Enter the total.**		
4	Enter total amount you paid for family members that are not qualified for the HCTC.		
5	**Subtract line 4 from line 3. Enter the total.**		
6	**Determine the Amount You Are Requesting for Reimbursement** Multiply line 5 by the amount of the tax credit. *For months January – April, multiply by 65% (.65)* *For months May – December, multiply by 80% (.80)* Enter the total amount here.		
7	**Enter total amount of National Emergency Grant (NEG) Payments Received.** Also, enter the number of months in which you received a NEG payment in box 7A.	Box 7a	
8	Subtract line 7 from line 6. **This is your Total Requested Reimbursement.**		

Part 3: Provide information about your qualified health insurance

You must provide proof of insurance, proof of payment, and any other required supporting documents for the health insurance policy you describe below.

☐ *I certify that my qualified health plan for this request for reimbursement is the same qualified health plan listed on my Monthly HCTC Registration Form.* ***If not, complete the following information.***

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
	Policy holders name (first, middle, last, suffix)		Policy holders social security number	Total monthly premium
	Total number of people (you and 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/yy)	End date for COBRA coverage (mm/dd/yy)
		☐ 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	Employers telephone number (include area code)
	Your last paid day of work for that employer	State date of non-group/individual insurance

**If you have this type of health plan, additional supporting documents are required. Refer to the Monthly HCTC Registration Form or visit www.irs.gov (Keyword/Search HCTC) for more details.*

Part 4: Gather supporting documents

You must provide copies of the corresponding health insurance bills or payment coupons for the months identified when submitting this form. These documents must show the following information:

- Your name (or name of the policy holder)
- The name of your health plan
- Your monthly premium amount
- Dates of coverage
- Your health plan identification number(s).

Note: If your qualified health plan does not provide members with an insurance bill or COBRA payment coupon, you must provide health plan enrollment documents or an official letter from your health plan that has the required information listed under a through e above.

You must also provide proof that you paid those premiums. Acceptable Proof of payment includes:

- Canceled checks (copy of front and back)
- Bank statements
- Credit card statements
- Money Order receipts

Note: Your proof of payment must indicate the amount paid and to whom it was paid. If you do not have one of these types of proof of payment, contact your health plan for a record of your payment(s).

Part 5: Sign and date this form

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

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PRIVACY ACT STATEMENT. ***This form is a draft intended for internal use only.***