HCTC Registration Form for Medicare Family Members

Complete this form to register your family members—or to continue their enrollment—in the monthly Health Coverage Tax Credit (HCTC) Program once you become Medicare eligible. Your family members may receive the HCTC for up to 24 months following your Medicare enrollment. *Please note that the American Recovery and Reinvestment Act which makes this possible ends December 31, 2010 unless re-authorized by Congress.*

Instructions:

1. Print or type your responses.
2. Sign and date this form.
3. Keep a copy of this completed form and all required supporting documents for your personal records.
4. **DO NOT SEND PAYMENT WITH THIS FORM.** Mail the completed form and supporting documents to:

HCTC Processing Center
P.O. Box 760189
San Antonio, TX 78245

Part 1: Provide information about you

Name *(first, middle initial, last, suffix)*	Gender
Date of Birth *(mm/dd/yyyy)*	Social Security Number
Mailing Address (street address)	City, State, Zip
Primary Telephone Number *(include area code)*	Medicare Eligibility Date *(Typically this is the date of your 65th birthday)*

Part 2: Confirm that the following statements are true

Check all boxes that apply. I certify that I am:

- Enrolled in Medicare, and I am completing this form to register my HCTC-qualified family members only.
- A Trade Adjustment Assistance (TAA), Alternative TAA recipient, or Re-employment TAA recipient, **or** Pension Benefit Guaranty Corporation (PBGC) payee and at least 55 years of age.
- Not claimed as a dependent on anyone's tax return.

Check all of the boxes that apply. I certify that neither I **nor my family member(s):**

- Can receive health coverage through the U.S. military health system (TRICARE).
- Are enrolled in the Children's Health Insurance Program (CHIP), or the Federal Employees Health Benefits Program (FEHBP).
- Are in prison.
- Are receiving a 65% COBRA Premium Reduction through a former employer or COBRA administration.
- Are covered by any health insurance plan where a former employer, or spouse's employer, pays 50% or more of the premiums.

Check all of the boxes that apply. I certify that **my family member(s):**

- Is covered by a qualified health insurance plan.
- Is not enrolled in Medicare Part A, B, or C.
- Is claimed as a dependent(s) on my tax return or I file jointly with my family member.

Part 4: Provide information about your family member(s)

If you have more than one eligible family member, make a copy of this page, and complete it for any additional family members.

Name (first, middle initial, last, suffix)	Date of Birth *(mm/dd/yyyy)*
Relationship to you:	Social Security Number
☐ Spouse ☐ Child ☐ Other	

Would you like for this individual to have authorized access to your account? ☐ Yes ☐ No

If yes, choose a Personal Identification Number (PIN). The PIN must be a five-digit ***number*** ☐☐☐☐☐

For more information about authorized individuals, please refer to your HCTC Program Kit.

Part 5: Provide health plan information about your family member(s)

Fill out the information below for you and your family member(s). If any of your family members have a separate health plan, make a copy of this page and complete it for each.

Check the box that applies:

- Although eligible for Medicare, I am covered by the insurance plan listed below.
- I am not covered by the plan listed below.

Complete this section	Name of Health Plan	Type of Coverage		
Complete this section only if your family members have COBRA coverage*.		☐ COBRA	☐ State-qualified	☐ Non-group/ individual
	Health plan ID number	Member ID	Group ID	Policy or plan ID
	Policy Holder's Name (first, middle, last,		Policy Holder's	Total monthly premium

	suffix)	Social Security number	
	Total number of people 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, including yourself		
	Extra monthly premium amount that covers dental or vision plans		
Complete this section only if your family members have COBRA coverage.	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		

Part 6: Gather supporting documents

Please send us:

A copy of your family's health insurance bill dated within the last 60 days. Make sure it has all of the following information:

- Your name
- Name and phone number of your health plan or administrator , the address for mailing your payments, health plan identification number(s)
- Monthly premium amount and monthly premium due date
- Dates of coverage

If necessary, the bill may need to show the following:

- Dollar amounts for family members who are not eligible for the HCTC
- Separate dollar amounts that do not count toward the HCTC (such as dental or vision coverage)

Note: Usually your health insurance bill will have all this information on it. If it doesn't, you must give us a letter from your health plan with this information on it.

If your family has **COBRA,** you also must send one of these documents:

- A copy of your completed and signed COBRA Election Letter. It may also be called a COBRA Enrollment Form, Application Form, Enrollment Application for Continuing Coverage, or Election Agreement; or
- A letter from your former employer or COBRA administrator saying you have COBRA. The letter must have:
  - The COBRA start and end dates.
  - The name of the health plan.
  - Your home address.
  - Covered family members, their dates of birth, their relationship to you, and their Social Security Numbers.
- A copy of the "Notice of Rights to Continue Coverage" and proof you have paid your bill. You can use a cancelled check or a credit card/bank statement dated within the past 60 days as proof.

If your family has **non-group/individual coverage**, you also must send both of these documents:

- A letter or other document from your former employer or your unemployment office that shows the date you left your job, and
- A document from your health plan that shows your first date of coverage.

Note: your first day of coverage in a non-group/individual health plan must have been at least 30 days before you left your job that made you eligible for PBGC or TAA benefits.

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 above.

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 7: 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

PAPERWORK REDUCTION ACT NOTICE. ***This form is a draft intended for internal use only.*** *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 30 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.