Form **14095** (July 2009)	Department of the Treasury–**Internal Revenue Service** **The Health Coverage Tax Credit (HCTC) Reimbursement Request Form**	**OMB No. 1545-2152**

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. Complete all parts of this form.
2. 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.
3. Mail the completed form and required supporting documents to:
   HCTC Processing Center
   P.O. Box 760189
   San Antonio, TX 78245
4. **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.

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: Determine eligibility and request reimbursement

Complete this section to request reimbursement. You can request reimbursement for premiums you paid for qualified coverage while you were eligible and enrolling in the monthly HCTC Program. For each month you are requesting reimbursement, you need to confirm that you 1) met all eligibility requirements for the HCTC and 2) made payments directly to a qualified health plan.

- For PBGC recipients- You can request reimbursement beginning with the ***month following the date*** printed on your HCTC Eligibility Certificate (sent with your original Program Kit) up to when you received your first invoice from the HCTC Program.*
- For TAA, ATAA, and RTAA recipients- You can request reimbursement beginning with the ***month of the date*** printed on your HCTC Eligibility Certificate (sent with your original Program Kit) up to when you received your first invoice from the HCTC Program.

**To ensure you receive information about the HCTC as quickly as possible, the HCTC Program sends the Program Kit (including the Eligibility Certificate) as soon as we receive your information from the PBGC, which is prior to the first month for which you can make a reimbursement request.*

Note: If you were eligible for the HCTC and paid for qualified coverage prior to the date on your HCTC Eligibility Certificate, you may be able to receive the HCTC when you file your federal tax return using IRS Form 8885.

Check the box next to each month of this calendar year for which you are requesting reimbursement and for which each of the following statements were 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*** enrolled in Medicare Part A, B, or C.
- You were ***not*** enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
- You were ***not*** enrolled in the Federal Employees Health Benefits Program (FEHBP) or enrolled in 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)*
- An employer did ***not*** pay 50% or more of the cost of coverage.

☐ 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 2009, multiply by 65% (.65)		
	For months May 2009 and months after, 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

Check the box below if your qualified health plan for this reimbursement request is the same plan used for your HCTC registration. If it is different, complete the table 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.**

Complete this section for all coverage types.	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
	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 (including 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 (including area code)	
	Your last paid day of work for that employer		Start date of non-group/individual insurance	

You are requesting reimbursement for a health plan that is different from your HCTC registration. You must provide documentation to show that this plan was qualified. 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 in Part 2 of 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 in the bullets 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**

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.

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