Form **XXXXX** (April 2010)	Department of the Treasury- Internal Revenue Service **The Monthly Health Coverage Tax Credit (HCTC) Group Registration Form**	**OMB No. XXXX-XXXX**

Part 1: Provide information about yourself

Name *(first, middle initial, last, suffix)*	Gender ☐ Male ☐ Female
Social Security Number (*SSN*)	Date of Birth (*mm/dd/yyyy)*
Primary Telephone Number *(include area code)*	

Part 2: Confirm Eligibility

Check the box below to confirm your eligibility for the HCTC.

☐ I certify that I meet all eligibility requirements for the HCTC as outlined in Part 2 of the Instructions.

Part 3: Provide information about family member(s)

Check the box below to confirm the eligibility of your family member(s) for the HCTC.

☐ I certify that each family member listed meets all eligibility requirements for the HCTC as outlined in Part 3 of the Instructions.

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*)	Relationship to you ☐ **Spouse** ☐ **Child** ☐ **Other**
Social Security Number (*SSN*)	Date of birth (*mm/dd/yyyy*)

Is this person on your health plan?
☐ **Yes** ☐ **No** He or she has a separate plan (use Part 4 to give this health insurance information, as applicable).

Is this person your third-party designee? ☐ **Yes** ☐ **No**	If yes, create five-digit Personal Identification Number (PIN).

Part 4: Provide information about your qualified health insurance

Part 4 is required. If your family member is not on your health plan, make a copy of this page to provide his/her qualified health insurance information.

You must complete this section.	Name of health plan	Type of coverage ☐ COBRA or VEBA	☐ State-qualified	
	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			
	Monthly premium amount that covers separate 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 this is a Lifetime Benefit	

**If you have this type of health plan, additional supporting documents are required. Visit www.irs.gov/hctc and click the "monthly program" link.*

Part 5: Gather supporting documents

If you need to provide supporting documents, include a copy of your health insurance bill dated within the last 60 days.

Part 6: 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**

Instructions for Form XXXXX

(April 2010)

The Monthly Health Coverage Tax Credit (HCTC) Group Registration Form

General Instructions

Please follow the instructions below to complete Form XXXXX. Print or type your responses and complete each part of this form. If you have any questions, 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.

Purpose of Form

Use this form to register for the monthly Health Coverage Tax Credit (HCTC) Program.

Complete Form XXXXX as Follows:

Part 1. Complete each line; all the information is required.

Part 2. Complete this section to confirm your eligibility for the HCTC.

Eligibility Requirements:

You or your family member(s) must be:

- An eligible Trade Adjustment Assistance (TAA), Alternative TAA (ATAA), or Reemployment TAA (RTAA) recipient; a Pension Benefit Guaranty Corporation (PBGC) payee and 55 years old or older; *OR* a qualified family member eligible for the HCTC due to the death of or divorce from a PBGC payee or TAA recipient.
- Covered by a qualified health plan for which you paid the premiums, or your portion of the premiums, directly to your health plan.
- Paying more than 50% of your health insurance premium. (i.e., an employer does not pay 50% or more of your premium.)
- Not enrolled in Medicare Part A, B, or C. *OR* you were enrolled, but are only claiming premiums for qualified family members.
- Not enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
- Not enrolled in the Federal Employees Health Benefits Program (FEHBP) or the U.S. military health system (TRICARE).
- Not imprisoned under federal, state, or local authority.
- Not receiving the 65% COBRA Premium Reduction through a former employer or COBRA administrator.

Part 3. Complete this section to confirm the eligibility of your family member(s) for the HCTC.

Eligibility Requirements:

Your family member(s) must:

- Be your spouse or claimed as dependent(s) on your tax return
- Meet the same requirements listed in Part 2 except the first bullet

To assign your family member as your Third-Party-Designee, create a five-digit Personal Identification Number (PIN). This person will be able to make changes to your account information, as well as ask and answer questions about your personal information.

Part 4. Complete this section to confirm your qualified health insurance.

Part 5. Include a copy of your health insurance bill dated within the last 60 days that includes *all* of the following:

1) Your name, 2) name and phone number of your Health Plan Administrator, 3) monthly premium amount, 4) monthly premium due date, 5) dates of coverage, 6) health plan identification numbers, and 7) address for mailing your payments.

Visit www.irs.gov/hctc and click on the "monthly program" link for more information on supporting documents.

Part 6. Print your full name, sign, and date the form.

Paperwork Reduction Act Notice and Privacy Act Statement

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 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.