Form **14117** (January 2010)	Department of the Treasury–**Internal Revenue Service** **HCTC Family Member Registration**	**OMB Number 1545-2162**

Family members of HCTC eligible individuals may receive the HCTC for up to 24 months following the eligible individual's Medicare enrollment. If you are an HCTC eligible individual, complete this form to register your family members—or to continue their enrollment—in the monthly Health Coverage Tax Credit (HCTC) Program as you enroll in Medicare. *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 ☐ Male ☐ Female
Date of Birth *(mm/dd/yyyy)*	Social Security Number *(SSN)*
Mailing Address *(street number)*	City, State, ZIP
Primary Telephone Number *(include area code)*	Date eligible for Medicare

Part 2: 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: ☐ Spouse ☐ Child ☐ Other	Social Security Number *(SSN)*

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 3: 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, or Re-employment TAA recipient, **or** Pension Benefit Guaranty Corporation (PBGC) payee and am 55 years old or older.
- ☐ Not claimed as a dependent on anyone's tax return.

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

- ☐ Can**not** receive health coverage through the U.S. military health system (TRICARE).
- ☐ Are **not** enrolled in the Children's Health Insurance Program (CHIP) or the Federal Employees Health Benefits Program (FEHBP).
- ☐ Are **not** in prison.
- ☐ Are **not** receiving a 65% COBRA Premium Reduction through a former employer or COBRA administration.
- ☐ Are **not** covered by any health insurance plan where a former employer, or spouse's employer, pays 50% or more of the premiums.

Check all 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 my spouse or is claimed as a dependent(s) on my tax return.

Part 4: 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 individual.

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.

Please complete this section.	Name of health plan	Type of coverage: ☐ COBRA ☐ State-qualified ☐ Non-group/individual ☐ VEBA (Only certain VEBAs qualify for the HCTC. Please see the HCTC Program Kit for more details.)		
	Health plan ID number	Member ID	Group ID	Policy or Plan ID
	Policyholder's name *(first, middle initial, last, suffix)*		Policyholder's SSN	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/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	Employer's telephone number *(include area code)*		
	Your last paid day of work for that employer	Start date of non-group/individual insurance		

**If you have this type of health plan, additional supporting documents are required. Visit www.irs.gov, and search for "HCTC." Click the link for "The Monthly HCTC."*

Part 5: 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, monthly premium due date, and 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 you have COBRA or non-group individual coverage, you will need to provide additional supporting documents that can be found on www.irs.gov; search for "HCTC."*

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 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**

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.