| Form **14116** (January 2010) | Department of the Treasury–**Internal Revenue Service** **HCTC Family Member Eligibility** | **OMB Number 1545-2163** |
|---|---|---|

## Part I: Provide Information About You

| Your name *(first, middle initial, last, suffix)* | Social security number |
|---|---|
| Your mailing address *(street number)* | *(city, state, ZIP)* |
| Telephone number | Gender: Male or Female |
| Your birth date *(mm/dd/yyyy)* | |

## Part II: Provide Information About Your Family Member Who Was HCTC Eligible

| Family member name *(first, middle initial, last, suffix)* | Family member birth date *(mm/dd/yyyy)* |
|---|---|
| Family member social security number | My family member is *(check one)*:<br>☐ A Trade Adjustment Assistance (TAA), Alternative TAA, or Reemployment TAA recipient<br>☐ A Pension Benefit Guaranty Corporation (PBGC) payee |

## Part III: Qualifying Event

| Check the box below next to the qualifying event:<br>☐ Death<br>☐ Divorce | Date of qualifying event *(mm/dd/yyyy)* |
|---|---|

## Part IV: Supporting Documentation

Please provide the HCTC program with one of the following supporting documents:

- Final Divorce Decree
- Death Certificate

Please mail the completed form and supporting documents to:

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

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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