Form **13560**
April 2007

Department of the Treasury — **Internal Revenue Service**

Health Plan Administrator (HPA) Return of Funds Form

OMB Number
1545-1891

Instructions for Returning Funds to the HCTC Program

- Contact your Finance & Accounting Representative and inform them of the pending return.
- Complete the HPA Return of Funds Form, and include it with your payment. This form MUST accompany all returned funds, in order to ensure proper handling. If your organization uses a similar form that provides ALL information requested below, submission of your internal document in lieu of this form is acceptable.
- Return funds using one of the following applicable options:

Send a HPA check (with company name and address):

Make check payable to US Treasury - HCTC, and reference "Account 100000000" in the memo field.
Complete this form, attach check, and MAIL to:

US Treasury - HCTC
PO Box 970023
St Louis MO 63197

Reversal of an EFT transaction:

Notify your bank that you want to reject the EFT, and request that they reverse the transaction back to the US Department of Treasury. Complete this form and FAX to:

Internal Revenue Service
HCTC Finance & Accounting Center
Attn: General Accounting & Reporting
FAX #: (800) 675-9602

Return a US Department of Treasury issued check:

Complete this form, attach check, and MAIL to:

Internal Revenue Service
Beckley Finance Center
PO Box 9002
Beckley WV 25802-9002

You can return funds for multiple individuals by using one of the following options: (1) Send a separate check and separate HPA Return of Funds Form, or, you can send an internal document for each individual, or, (2) Send one check as a bulk payment, and attach a detailed list that defines how the bulk payment should be allocated. This list must include all information that is required on the HPA Return of Funds Form, for each individual for whom you are returning funds (listed below). *****Remember, before returning funds to the HCTC Program, you must contact your Finance & Accounting Representative.**

Use one form per insured, completing all sections below. Please mark N/A wherever applicable.

Insured Name: ______________________________ SSN: ______________

Date Coverage Ended: __________ Reason for Termination: ______________________________

Total Amount Returned: __________ Is this a prorated amount? __________

If the returned funds are a prorated amount, what portion is Medical? ______________ OT? ______________

Are the returned funds the result of a premium change? __________ If so, what is the new medical amount? __________

OT amount? __________ What is the effective date of the new premium? __________

Is any portion of the returned funds money that the insured sent directly to the HPA (outside of HCTC)? ______

If so, how much? __________

Month 1: Date of EFT or Check: ______________	Month 2: Date of EFT or Check: ______________
# of Days Returning: ______________	# of Days Returning: ______________
Medical Amount: ______________	Medical Amount: ______________
OT Amount: ______________	OT Amount: ______________
Total Amount Returned: ______________	Total Amount Returned: ______________

Medical = Premium amount major medical coverage. **OT** = Premium amount for vision, dental, riders, or other coverage paid outside the major medical premium amount each month.

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

Health Plan Administrator (HPA) Return of Funds Form

Instructions for Returning Funds

1. Contact your Finance & Accounting Representative and inform them of the pending return.
2. Complete the HPA Return of Funds Form and send it with your payment. **This form MUST accompany all returned funds, in order to ensure proper handling.**
3. Return funds by using one of the following applicable options:
   - Reversal of an EFT transaction:

     Notify your bank that you wish to reject the EFT and request that they reverse the transaction back to the U.S. Department of Treasury, and,

     Send this form by **FAX** to:

     Internal Revenue Service
HCTC Finance & Accounting Center
Attn: General Accounting & Reporting
Fax Number: 1-800-675-9602
   - Return a U.S. Department of Treasury issued check:

     Attach the check to this form and **MAIL** to:

     Internal Revenue Service
Beckley Finance Center
P.O. Box 9002
Beckley, WV 25802-9002
   - Send an HPA issued check:

     Make check payable to ***US Treasury***. Reference the code "***Acct. 100000000***" in the memo field of the check, and,

     Attach the check to this form and **MAIL** to:

     US Treasury – HCTC
P.O. Box 970023
St. Louis, MO 63197

** You may return funds for **multiple individuals** by completing one of the following options: (1) Send separate checks and a single, completed HPA Return of Funds Form for each individual. (2) Send one bulk payment and attach a detailed list that describes how the bulk payment should be allocated. This list MUST include the information requested on the HPA Return of Funds Form for each individual, for whom you are returning funds.*

Returned Funds Details

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 20 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. Do **NOT** send this form to this address. Instead, enclose it with the magnetic tape and send it to the Service Center to which you submit your tapes or send it to the transmission reception site that received your transmitted returns.

Participant Name: ______________________

Participant SSN: ______________________

Plan/Group ID: ______________________

Amount of Returned Funds: ______________________

Reason for Returned Funds: