

**HEALTH COVERAGE TAX CREDIT (HCTC)  
ADMINISTRATIVE CHANGES FORM**

**Use this form to submit changes to information currently on file with HCTC. Fax the completed form to (800) 675-9602 at least 30 days prior to the effective date.**

**COMPANY INFORMATION**

Legal Name:	EIN/TIN (Associated with Legal Name):	HPA Telephone Number:
Legal Address:	HPA FAX Number:	HPA Email Address:
HPA Contact Name:	HPA Contact Mailing Address:  Attention:	Other:

**PAYMENT/REMITTANCE ADVICE CONTACT INFORMATION**

Name:	Telephone Number:	FAX Number:
Address:	Email Address:	Other:
Attention:		

**FINANCIAL INSTITUTION INFORMATION**

Financial Institution's Name:	Bank Account Type (checking or savings):	Telephone Number (optional):
Address (optional)	Nine Digit ABA Routing Number:	Bank Account Number:

**SIGNATURE OF AUTHORIZED OFFICIAL**

Signature:	Printed/Typed Name:
Title:	Date: