

Use this form to make updates to your monthly Health Coverage Tax Credit (HCTC) account. When you or your family members are enrolled in the monthly HCTC program, you must inform us of all changes that affect your eligibility, your family members, and your health insurance. If you do not keep your HCTC account information current, you could risk losing the Monthly HCTC.

**Instructions:**

1. **Keep a blank copy** of this form in your personal records for future use. This form can also be found at [www.irs.gov/hctc](http://www.irs.gov/hctc).
2. Only use this form if you need to make **changes** to your HCTC account.
3. **Print or type** your responses. Leave blank any box that does not apply to you or your family members.
4. You must complete Part 5.
5. You must sign and date this form to confirm your continued eligibility for the HCTC.
6. Keep a copy of this completed Registration Update Form—and all required supporting documents—for your personal records.
7. **DO NOT SEND PAYMENT WITH THIS FORM.** Mail the completed form and required supporting documents to:  
**HCTC Processing Center**  
 P.O. Box 760189  
 San Antonio, TX 78245

*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 1: Provide information about you**

Name (First, Middle Initial, Last, Suffix)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number (SSN)	Date of Birth (mm/dd/yyyy)	Primary Phone Number	Check here if address or phone has changed <input type="checkbox"/>
Your Mailing Address (Street Address)		City, State, Zip	

**Note:** You must also provide mailing address changes to the agency that reports you as eligible for the HCTC Program. This is either your state (unemployment office) or the Pension Benefit Guaranty Corporation (PBGC).

**Part 2: Confirm your eligibility**

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

- I certify that **all** of the following statements are true.
- I am an eligible Trade Adjustment Assistance (TAA), Alternative TAA (ATAA), or Reemployment TAA (RTAA) recipient; OR a Pension Benefit Guaranty Corporation (PBGC) payee.
  - I am covered by a qualified health plan for which I pay more than 50% of the premiums. (An employer does not pay 50% or more of my premiums.)
  - I am not enrolled in Medicare Part A, B, or C.
  - I am not enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
  - I am not enrolled in the Federal Employees Health Benefits Program (FEHBP).
  - I am not enrolled in the U.S. military health system (TRICARE).
  - I am not imprisoned under federal, state, or local authority.
  - I am not claimed as a dependent on someone else's federal income tax return.

**If you do not certify all of the statements above, you are no longer eligible to receive the HCTC and should not submit this form. Instead, call the HCTC Customer Contact Center to tell us about this change.**

**Part 3: Tell us what to change on your HCTC account**

Check all that apply.	Effective Date of Change (mm/dd/yyyy)
<input type="checkbox"/> Add or remove a family member.	
<input type="checkbox"/> Change information about my or my family member's current health insurance (e.g., change in premium amount, change in any ID numbers, change in address where payments are currently sent).	
<input type="checkbox"/> The administrator for my COBRA coverage has changed (COBRA only).	
<input type="checkbox"/> I or my family member(s) have <i>new</i> HCTC qualified health insurance.	
<input type="checkbox"/> Switch my eligibility type from TAA (or ATAA/RTAA) to PBGC.	
<input type="checkbox"/> Check this box to reactivate my HCTC account if I was enrolled within the last 90 days.	

**Reason for update**

<b>Part 4: Provide information about a family member</b>	Add eligible family member <input type="checkbox"/>
	Remove ineligible family member <input type="checkbox"/>

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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Social Security Number	Date of Birth (mm/dd/yyyy)

Is this person on your health plan?

Yes  No This person has a separate plan. Make a copy of this page and use Part 5 to provide this health insurance information, as applicable.

### Part 5: Provide information about your qualified health insurance

**Part 5 is required.** You must submit proof of insurance (e.g., a current bill) and any other required documents for the health insurance policy you describe below. For detailed information on the supporting documents you must submit, visit [www.irs.gov/hctc](http://www.irs.gov/hctc).

Please complete this section.	Type of Coverage: <input type="checkbox"/> COBRA <input type="checkbox"/> State-qualified <input type="checkbox"/> Non-group/individual <input type="checkbox"/> VEBA (Only certain VEBA's qualify for the HCTC)		
	Name of Health Plan		Health Plan ID Number
	Please provide at least one of the following ID Numbers.		
	Member ID	Group ID	Policy or Plan ID
	Policy Holder's Name (First, Middle Initial, Last, Suffix)	Policy Holder'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		
	Portion of monthly premium that covers a separate dental or vision plan		
Complete this section only if you have COBRA coverage.*	Former Employer	Former Employer's HR Phone Number	
	Start Date for COBRA Coverage (mm/dd/yyyy)	End Date for COBRA Coverage (mm/dd/yyyy) <input type="checkbox"/> Check here if this is a 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 Phone Number	
	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. For a list of the supporting documents visit [www.irs.gov/hctc](http://www.irs.gov/hctc) and click the "Monthly HCTC" link.

### Part 6: Sign and date this form to confirm your HCTC eligibility

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 authorize the HCTC Program to independently discuss with my health insurer, third party administrator or former employer, my eligibility status and HCTC payments made on my behalf to these organizations.

Signature	Full Name (print)	Date
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**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.