

Instructions for Form 13441-EZ

(Rev. June 2011)

Monthly Health Coverage Tax Credit (HCTC) Group Registration



Department of the Treasury
Internal Revenue Service

General Instructions

Please follow the instructions below to complete Form 13441-EZ. Print or type your responses. If you have any questions, 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).

Purpose of Form

Use this form during an HCTC Program-sponsored group registration for the monthly Health Coverage Tax Credit (HCTC) Program.

Complete Form 13441-EZ as Follows:

Part 1. Complete each line.

Part 2. Complete this section to confirm your eligibility for the HCTC.

Eligibility Requirements for the HCTC:

You must be:

- An eligible Trade Adjustment Assistance (TAA), Alternative TAA (ATAA), or Reemployment TAA (RTAA) recipient; *OR* a Pension Benefit Guaranty Corporation (PBGC) payee who is 55 years old or older.
- Covered by a qualified health plan for which you paid the premiums, or your portion of the premiums, directly to your health plan.
- Paying more than 50% of your health insurance premium after-tax (i.e., an employer does not pay 50% or more of your premium).
- Not enrolled in Medicare Part A, B, or C.
- Not enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
- Not enrolled in the Federal Employees Health Benefits Program (FEHBP).
- Not enrolled in the U.S. military health system (TRICARE).
- Not imprisoned under federal, state, or local authority.
- Not claimed as a dependent on someone else's federal income tax return.

Part 3. Complete this section to confirm the eligibility of your family member(s) for the HCTC.

Eligibility Requirements for the HCTC:

Your family member(s) must:

- Be your spouse or claimed as dependent(s) on your federal income tax return.
- Meet the same requirements listed in Part 2 except the first and last bullets.

To assign your family member as your third-party designee, create a five-digit Personal Identification Number (PIN). This person will be able to make changes to your account information, as well as ask and answer questions about your personal information.

Part 4. Complete this section to confirm your qualified health insurance.

If you have a health plan through a VEBA:

You must attest by signing this form that you chose this health plan through a VEBA that was established as a result of your former employer's bankruptcy, and was offered to you in lieu of COBRA coverage and retiree benefits.

Part 5. If certain information is not provided by your former employer, you may need to provide a copy of your health insurance bill dated within the last 60 days. If you have COBRA coverage, you may need to provide additional documents. Visit www.irs.gov/hctc and click on the "monthly HCTC" link for more information on supporting documents.

Part 6. Print your full name, sign, and date the form.

Paperwork Reduction Act Notice and Privacy Act Statement

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.

Form 13441-EZ (Rev. June 2011)	Department of the Treasury—Internal Revenue Service Monthly Health Coverage Tax Credit (HCTC) Group Registration	OMB Number 1545-1842
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Part 1: Provide information about yourself

Name (<i>first, middle initial, last, suffix</i>)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number (SSN)	Date of Birth (<i>mm/dd/yyyy</i>)
Primary Telephone Number (<i>include area code</i>)	Former Employer

Part 2: Confirm Eligibility

Check the box below to confirm your eligibility for the HCTC.
 I certify that I meet all eligibility requirements for the HCTC as outlined in Part 2 of the Instructions.

Part 3: Provide information about family member(s)

Check the box below to confirm the eligibility of your family member(s) for the HCTC.
 I certify that each family member listed meets all eligibility requirements for the HCTC as outlined in Part 3 of the Instructions.

Make a copy of this page before filling it out if you have more family members than the space allows and indicate the number of family members here. **Number of family members** _____

Family member's name (<i>first, middle initial, last, suffix</i>)	Relationship to you <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Social security number (SSN)	Date of birth (<i>mm/dd/yyyy</i>)

Is this person on your health plan?
 Yes No This person has a separate plan (use Part 4 to provide this health insurance information, as applicable).

Is this person your third-party designee? (See Part 3 of the Instructions) If yes, create a five-digit Personal Identification Number (PIN)
 Yes No

Part 4: Provide information about your qualified health insurance

If your family member is not on your health plan, make a copy of this page to provide their qualified health insurance information.

Please see Part 4 of the Instructions and complete this section.	Type of Coverage: <input type="checkbox"/> COBRA <input type="checkbox"/> VEBA <input type="checkbox"/> State-qualified	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 (<i>first, middle initial, last, suffix</i>)		Start date for coverage (<i>mm/dd/yyyy</i>)
	Policy holder's social security number		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.	Your former employer	Former employer's HR phone number (<i>include area code</i>)	
	End date for COBRA coverage (<i>mm/dd/yyyy</i>)	<input type="checkbox"/> Check here if this is a Lifetime Benefit	

Part 5: Gather supporting documents

Please see Part 5 of the Instructions for information on supporting documents.

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 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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