Health Coverage Tax Credit

Registration Form

HCTC
Federal • State • Private Industry
Health Coverage
Tax Credit

Privacy Act and Paperwork Reduction Act Notice

The Privacy Act of 1974 and the Paperwork Reduction Act of 1995 require that when we ask you for information we must first tell you our legal right to ask for the information, why we are asking for it, and how it will be used. We must also tell you what could happen if we do not receive it and whether your response is voluntary, required to obtain a benefit, or mandatory under the law.

We ask for the information on this form to carry out the Internal Revenue laws of the United States. If you are eligible, section 35 of the Internal Revenue Code allows a credit for payments you made to buy certain types of health coverage during the tax year. Section 7527 lets you authorize your health coverage provider to receive this credit in advance in the form of monthly payments from the Internal Revenue Service.

The information you submit is used to determine if you qualify for the advance payment of the Health Coverage Tax Credit (HCTC). If you fail to provide the information, or provide inaccurate information, your application may be denied. However, you may still qualify for the HCTC when you file your federal tax return.

The estimated average time to complete this form is 30 minutes. 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 be material in the administration of any Internal Revenue laws.

Generally, tax returns and return information (tax information) are confidential, as stated in Code section 6103. However, Code section 6103 allows or requires the Internal Revenue Service to disclose or give the information to others as described in the Code. For example, we may give the information provided to us to your health plan administrator for the purposes of the HCTC program. We may disclose the information you provide to contractors for tax administration purposes. We may also disclose this information to the Department of Justice, to enforce the tax laws, both civil and criminal; to other federal agencies; to states, the District of Columbia, and U.S. commonwealths or possessions in order to carry out their tax laws; and to certain foreign governments under tax treaties they have with the United States.

Please keep a copy of this notice for your records. It may help you if we later ask you for other information. If you have any questions about the rules for filing and giving information, please call the HCTC Customer Contact Center at 1-866-628-HCTC (1-866-628-4282). TDD/TTY callers, please call 1-866-626-HCTC (1-866-626-4282).

If you have any comments concerning the accuracy of the time estimate to complete this form or suggestions to make this form simpler, we would be happy to hear from you. You can write to the Tax Forms Committee, Western Area Distribution Center, Rancho Cordova, CA 95743-0001. DO NOT send the form to this office.

Health Coverage Tax Credit Registration Form

OMB No. 1545-1842

The Health Coverage Tax Credit (HCTC) program must receive this form and the requested documents in order to process your registration.

Before you begin:

- Read the HCTC Program Kit to obtain definitions and to understand the eligibility requirements for you and your family members.
- Locate the health plan invoices for you and any qualified family members and, if applicable, COBRA election letters.

Pension Benefit Guaranty Corporation (PBGC) Recipients Only: If you currently receive benefits from the PBGC as a survivor, a beneficiary, or an alternate payee under a qualified domestic relations order and you are at least 55 years old, you are considered to be the HCTC candidate. You should read and answer the questions on this Registration Form from this point of view.

Instructions:

1. Type or print your answers legibly in black ink *(if your answers are not legible, the form can not be processed).*
2. Enter your Social Security Number (SSN) or Taxpayer Identification Number (TIN) at the bottom of each page where indicated.
3. Read the instructions for each section to understand what type of information to provide in that section.
4. Enter only valid U.S. addresses where address information is required.
5. Enter "N/A" in any field that does not apply to you or to your qualified family member(s).
6. Sign and date this form on page 6.
7. Keep a copy of this completed Registration Form and any required documents for your personal records.

Part I: Complete This Part to Provide Information About You

YOUR INFORMATION			
1. SSN or TIN	2. Date of Birth (mm/dd/yyyy)		
3. Last Name	4. First Name	5. Middle Name	6. Suffix (Jr., II)
7. Mailing Address	8. City	9. State/Territory	10. Zip Code
11. Telephone Number (include area code and extension) Primary ( ) Alternate ( )	12. Preferred Language For Mailings (mark only one of the following) ☐ English ☐ Spanish ☐ Braille ☐ English - Large Print ☐ Spanish - Large Print		

Part II: Complete This Part to Determine Your Eligibility

1. Are you any of the following: (Check the box next to all that apply)

   ☐ Receiving a Trade Readjustment Allowance (TRA) under the Trade Adjustment Assistance (TAA) program or would be receiving a TRA except that you have not used up your unemployment insurance (UI) benefits

   ☐ Receiving a pension benefit from the Pension Benefit Guaranty Corporation (PBGC) and are at least 55 years old

   ☐ Receiving benefits under the Alternative Trade Adjustment Assistance (ATAA) program
   If you only checked the ATAA box, you must call the HCTC Customer Contact Center before filling out this form.

   Did you check any of the boxes above?

   ☐ No. Stop; you are not eligible to register for the advance credit at this time.

   ☐ Yes. Go to question 2.

2. Are you currently any of the following: (Check the box next to any that apply)

   ☐ Enrolled in a health plan maintained by an employer or former employer that pays at least 50% of the cost of coverage (This includes any amount contributed on a pre-tax basis.)

   ☐ Entitled to Medicare Part A or enrolled in Medicare Part B

   ☐ Enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP)

   ☐ Enrolled in the Federal Employees Health Benefits Program (FEHBP)

   ☐ Entitled to health coverage through the U.S. military health system (TRICARE/CHAMPUS)

   ☐ Enrolled in a health plan maintained by your spouse's employer or former employer that pays at least 50% of the cost of coverage (This includes any amount contributed on a pre-tax basis.)

   Did you check any of the boxes above?

   ☐ No. Go to question 3.

   ☐ Yes. Stop; you are not eligible to register for the advance tax credit at this time.

3. Can you be claimed as a dependent on someone else's federal tax return this year?

   ☐ No. Go to question 4.

   ☐ Yes. Stop; you are not eligible to register for the advance tax credit at this time.

4. Are you imprisoned under federal, state or local authority?

   ☐ No. Go to question 5.

   ☐ Yes. Stop; you are not eligible to register for the advance tax credit at this time.

5. Are you covered by a qualified health plan?
   See Step 2 in the HCTC Program Kit for the definition of a qualified health plan.

   ☐ No. Stop; you are not eligible to register for the advance tax credit at this time.

   ☐ Yes. Go to question 6.

6. Is your qualified health plan sponsored by your spouse's employer?

   ☐ No. Go to question 7.

   ☐ Yes. If the health plan is COBRA continuation coverage, go to question 7. Otherwise, **stop**. You are not eligible for the advance payment option. If the employer pays for less than 50% of the cost of coverage, you may be able to claim the credit when you file your federal tax return.

7. Check the box next to the qualified health plan you have.

   ☐ COBRA continuation coverage where the employer/former employer pays less than 50% of the cost of coverage (This includes your or your spouse's COBRA coverage.)

   ☐ HCTC state-qualified health plan

   ☐ Individual coverage in which you were enrolled for at least 30 days prior to separation from the job that made you TRA eligible, ATAA eligible, and/or PBGC eligible

Claiming the Credit for Qualified Family Members

See Step 1 in the HCTC Program Kit for the definition of a qualified family member before answering question 8.

8. Do you have any qualified family members for whom you wish to claim the advance tax credit?

   ☐ No. Skip questions 9-11 and go to **Part III** on **page 5**.

   ☐ Yes. Go to question 9.

9. Answer this question for each family member for whom you wish to claim the credit. After answering this question for all of these family members, follow the instructions below.

   Is the family member:

   - Enrolled in a health plan maintained by the family member's employer or former employer that pays at least 50% of the cost of coverage (This includes any amount contributed on a pre-tax basis.)
   - Entitled to Medicare Part A or enrolled in Medicare Part B
   - Enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP)
   - Enrolled in the Federal Employees Health Benefits Program (FEHBP)
   - Entitled to health coverage through the U.S. military health system (TRICARE/CHAMPUS)

   If you answered yes to any part of question 9 for any family member, that family member does not meet the definition of a qualified family member and you will not be able to claim the advance tax credit for them at this time.

   If you answered no to ALL parts of question 9 for any family members, go to question 10 for those family members.

10. Are all of your qualified family members covered by qualified health plans?
    See Step 2 in the HCTC Program Kit for the definition of a qualified health plan.

    ☐ No. Stop; if a family member is not covered by a qualified health plan, that family member does not meet the definition of a qualified family member and you will not be able to claim the advance tax credit for them at this time. Go to **Part III** on **page 5**.

    ☐ Yes. Go to question 11.

11. Are all of your qualified family members covered on your health plan policy?

    ☐ No. Complete **Part III** on **page 5** to provide information about your qualified health plan. Read the instructions at the bottom of **page 5** on how to report family members who have their own qualified health plan policy.

    ☐ Yes. Complete **Part III** on **page 5** to provide information about your qualified health plan. Read the instructions at the bottom of **page 5** on how to report family members who are on your health plan policy.

Part III: Complete This Part to Provide Information About Your Qualified Health Plan

1. Complete this section and the worksheet on **page 6** to provide information about your qualified health plan.

YOUR QUALIFIED HEALTH PLAN INFORMATION		
1. Member ID	2. Group ID	3. Policy ID
4. Policy Holder's Name (Last, First, Suffix)	5. Policy Holder's SSN or TIN	
6. Total Number of People Both Qualified and Non-Qualified on This Health Plan Policy	7. Number of Non-Qualified People on This Health Plan Policy	

If your qualified health plan is COBRA, you must also provide the following information:

FORMER EMPLOYER INFORMATION	
1. Former Employer's Name	2. Former Employer's Telephone Number (include area code) ( )

2. You must also include proof of insurance for each qualified health plan policy when you submit this form.
   - **COBRA** – Include a copy of the COBRA election letter and a copy of the current month's health plan invoice
   - **HCTC state-qualified or qualified individual coverage** – Include a copy of the current month's health plan invoice

   The HCTC program will use these documents to verify the health plan information provided, to determine the HCTC-eligible premium amount and to calculate your monthly payment responsibility for the policy.

   Any health plan invoice sent must list as a separate line item any premium amounts paid for:
   - Non-qualified family members on the health plan policy
   - Exceptions on the health plan policy
     See Step 4 in the HCTC Program Kit for the definition of exceptions.

   If the invoice does not meet the two criteria above, you must provide a letter from the health plan administrator that lists the amounts paid for non-qualified family members and for exceptions as separate line items from the major medical expenses/premiums on the policy.

Complete the worksheet on page 6 and sign and date the form. In addition:

- If you do not have any family members who are eligible for the credit, turn to **page 10** for details on how to submit your completed Registration Form.
- If you have qualified family members for whom you wish to claim the advance credit and they are on your health plan policy, complete **Part IV** on **page 7.**
- If you have qualified family members for whom you wish to claim the advance credit and they have their own qualified health plan policy, complete **Part V** on **page 8**.

Estimate the Payment Responsibility for You and All Qualified Family Members on Your Health Plan Policy

1. Use this worksheet to provide the HCTC program an estimate of your HCTC-eligible monthly premium amount and your estimated monthly payment responsibility for this health plan policy.

Please note: The actual amounts will be calculated using the health plan invoice you provide.

1. Enter the total monthly premium paid for the health plan policy . . . . . (1) $ _____.
2. Enter the total monthly premium paid for non-qualified family members on your policy. . . . . (2) $ _____.
3. Enter the total of monthly premiums paid for exceptions on this policy (for example, vision and dental coverage). . . . . (3) $ _____.
4. Enter the amount of your monthly premium that you pay using funds from an Archer MSA (Medical Savings Account). . . . . (4) $ _____.
5. Add lines 2, 3 and 4. Enter the result here. This is the estimated total monthly **ineligible** premium amount. . . . . (5) $ _____.
6. Subtract line 5 from line 1 and enter the result here. This is the estimated monthly **HCTC-eligible** premium amount. . . . . (6) $ _____.
7. Multiply line 6 by 35% (.35) and enter the result here. . . . . (7) $ _____.
8. Add lines 5 and 7. This is an estimate of your **total** monthly payment responsibility for this policy. . . . . (8) $ _____.

THIRD PARTY DESIGNEE

A third party designee is someone you would like to authorize to access and update your HCTC account.

If you want to allow a friend, family member, or any other person you choose to discuss your HCTC account with the HCTC program, check the "Yes" box in the "Third Party Designee" area below. You will need to enter the designee's name, phone number, and any five numbers the designee chooses as his or her personal identification number (PIN). The PIN will be used to identify the designee if they contact the HCTC program.

Do you want to allow another person to discuss your HCTC account with the HCTC program?

☐ No.
☐ Yes. Complete the following:

Designee's Full Name (type or print legibly)	Telephone Number (include area code)	Personal Identification Number (PIN)
		☐☐☐☐☐

Under penalties of perjury, I declare that the information furnished on this form with regard to myself and to any qualified family member(s), and any attachments to it, are true, correct, and complete. I understand that a knowing and willfully false statement on this form can result in my disqualification from participating in the advance tax credit program. By signing, I also agree to allow the IRS to share my eligibility status and payment information with my health plan administrator.

Signature (sign in black ink)	**Full Name (type or print legibly)**	**Date Signed**
▶		

Part IV: Complete This Part to Provide Information About Qualified Family Members on Your Health Plan Policy

1. If your qualified family members are on your health plan policy, complete the information below. You must provide information for each of the family members in a separate box.
2. Photocopy this page before filling it out if you have more family members than the space below allows.

INFORMATION FOR QUALIFIED FAMILY MEMBER #1			
1. SSN or TIN	2. Date of Birth (mm/dd/yyyy)	3. Member ID	4. Relationship ☐ Spouse ☐ Child ☐ Other
5. Last Name	6. First Name	7. Middle Name	8. Suffix (Jr., II)

INFORMATION FOR QUALIFIED FAMILY MEMBER #2			
1. SSN or TIN	2. Date of Birth (mm/dd/yyyy)	3. Member ID	4. Relationship ☐ Spouse ☐ Child ☐ Other
5. Last Name	6. First Name	7. Middle Name	8. Suffix (Jr., II)

INFORMATION FOR QUALIFIED FAMILY MEMBER #3			
1. SSN or TIN	2. Date of Birth (mm/dd/yyyy)	3. Member ID	4. Relationship ☐ Spouse ☐ Child ☐ Other
5. Last Name	6. First Name	7. Middle Name	8. Suffix (Jr., II)

INFORMATION FOR QUALIFIED FAMILY MEMBER #4			
1. SSN or TIN	2. Date of Birth (mm/dd/yyyy)	3. Member ID	4. Relationship ☐ Spouse ☐ Child ☐ Other
5. Last Name	6. First Name	7. Middle Name	8. Suffix (Jr., II)

- If you are not claiming the credit for any eligible family members on their own health plan policy, turn to **page 10** for details on how to submit your completed Registration Form.
- Only complete **Part V** on **pages 8 and 9** if you have qualified family members who have their own qualified health plan policy.

Part V: Complete This Part to Provide Information About Qualified Family Members Listed on a Separate Qualified Policy

1. Complete this section and the worksheet on **page 9** to provide information about qualified family members with their own qualified health plan policy.
2. Photocopy this page before filling it out if you have more family members than the space below allows.
3. You must also include proof of insurance for each qualified health plan policy you are trying to claim when you submit this form. See **page 5** for instructions on what required documents you must submit.

INFORMATION FOR QUALIFIED FAMILY MEMBER			
1. SSN or TIN	2. Date of Birth (mm/dd/yyyy)	3. Relationship ☐ Spouse ☐ Child ☐ Other	
4. Last Name	5. First Name	6. Middle Name	7. Suffix (Jr., II)

YOUR QUALIFIED FAMILY MEMBER'S HEALTH PLAN POLICY INFORMATION		
1. Member ID	2. Group ID	3. Policy ID
4. Policy Holder's Name (Last, First, Suffix)	5. Policy Holder's SSN or TIN	
6. Total Number of People Both Qualified and Non-Qualified on This Health Plan Policy	7. Number of Non-Qualified People on This Health Plan Policy	

What type of qualified health plan policy does this family member have?

- ☐ COBRA continuation coverage where the employer/former employer pays less than 50% of the cost of coverage
- ☐ HCTC state-qualified health plan
- ☐ Other qualified individual coverage

If the family member's qualified health plan is COBRA, you must also provide the following information:

FORMER EMPLOYER INFORMATION	
1. Former Employer's Name	2. Former Employer's Telephone Number (include area code) ( )

Complete the worksheet on **page 9** to provide the HCTC program an estimate of the HCTC-eligible monthly premium amount and your estimated monthly payment responsibility for this family member's health plan policy.

Estimate the Payment Responsibility for Your Qualified Family Member's Health Plan Policy

1. Use this worksheet to provide the HCTC program an estimate of the HCTC-eligible monthly premium amount and your estimated monthly payment responsibility for this health plan policy.

Please note: The actual amounts will be calculated using the health plan invoice you provide.

1. Enter the total monthly premium paid for the health plan policy . . . . . (1) $ _____.____

2. Enter the total monthly premium paid for non-qualified family members on this policy. . . . . (2) $ _____.____

3. Enter the total of monthly premiums paid for exceptions on this policy (for example, vision and dental coverage). . . . . (3) $ _____.____

4. Enter the amount of the monthly premium for this policy that is paid using funds from an Archer MSA (Medical Savings Account). . . . . (4) $ _____.____

5. Add lines 2, 3 and 4. Enter the result here. This is the estimated total monthly **ineligible** premium amount. . . . . (5) $ _____.____

6. Subtract line 5 from line 1 and enter the result here. This is the estimated monthly **HCTC-eligible** premium amount. . . . . (6) $ _____.____

7. Multiply line 6 by 35% (.35) and enter the result here. . . . . (7) $ _____.____

8. Add lines 5 and 7. This is an estimate of your **total** monthly payment responsibility for this policy. . . . . (8) $ _____.____

Turn to **page 10** for details on how to submit your completed Registration Form.

Attach to This Page:

A copy of the current month's health plan invoice(s) for you and any qualified family members
and
If you or your qualified family members have COBRA, also attach
a copy of the COBRA election letter(s).

Before You Mail the Registration Form, Did You Remember To:

1. Complete all required sections of the Registration Form?
2. Sign and date the Registration Form on **page 6**?
3. Put your SSN or TIN at the bottom of each page of this Registration Form where indicated.
4. Attach all necessary health plan verification documents to this page for you and your qualified family members?
5. Keep a copy of your completed HCTC Registration Form and any required documents for your personal records?

Mail your complete HCTC Registration Form and all required documents in the enclosed postage paid envelope.

Or, mail it to:

HCTC Processing Center
P.O. Box 4700
Waterloo, IA 50701

Please note, the registration process typically takes **4 to 6 weeks** to complete. You should continue to pay **100%** of your health plan premium directly to your health plan administrator until you receive confirmation from the HCTC that you have been registered for the advance payment option of the HCTC.

Thank you for completing the HCTC Registration Form!

Need Assistance?

Call toll-free 1-866-628-HCTC (1-866-628-4282)

TDD/TTY callers, please call 1-866-626-HCTC (1-866-626-4282)

Or visit us on the Web at http://www.irs.gov (IRS keyword: HCTC).

Department of the Treasury
Internal Revenue Service

Publication 4181 (Rev. 7-2003)
Catalog Number 36370X