Form **14116**
(August 2013)

Department of the Treasury - Internal Revenue Service

HCTC Family Member Eligibility

OMB Number
1545-2163

Part I: Provide Information About You

Name *(First, Middle Initial, Last, Suffix)*

Gender	Social Security Number (SSN)	Your Date of Birth *(mm/dd/yyyy)*
☐ Male ☐ Female		

Your Primary Phone Number	Your Alternate Phone Number

Mailing Address *(Street Number, City, State, ZIP code)*

Part II: Provide Information About Your Family Member Who Was HCTC Eligible

Family Member Name *(First, Middle Initial, Last, Suffix)*

Family Member Social Security Number	Family Member Date of Birth *(mm/dd/yyyy)*

At the time of the event my family member was *(Check One)*

☐ A Trade Adjustment Assistance (TAA), Alternative TAA, or Reemployment TAA recipient

☐ A Pension Benefit Guaranty Corporation (PBGC) payee

Part III: Qualifying Event

Check the box below next to the qualifying event:	Date of Qualifying Event *(mm/dd/yyyy)*
☐ Death ☐ Finalized a Divorce	

Part IV: Supporting Documentation

Please provide the HCTC Program with one of the following supporting documents:

- Final Divorce Decree
- Death Certificate

Please fax the completed form and supporting documents from a secure fax line to:

IRS - HCTC Program
Fax: 866-303-5298

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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