Form **13560**
(May 2017)

Department of the Treasury - Internal Revenue Service

Health Plan Administrator (HPA) Return of Funds

OMB Number
1545-1891

Instructions for Returning Funds to the HCTC Program

- This form is for returning the Government's portion of the insurance premium ONLY. The participant's portion must be returned directly to the participant.
- When completing the Insured section, fill in the last four digits of insured's social security number.
- Complete the HPA Return of Funds form, and include it with your payment. This form MUST accompany all returned funds, in order to ensure proper handling. If your organization uses a similar form that provides ALL information requested below, submission of your internal document in lieu of this form is acceptable.
- If more then one participants is impacted by the return of the Government's Portion you must include a detail listing of all participants including Insured Names, last 4 digits of SSN, Participant's PIN, Date Coverage Ended, Reason for termination, total amount returned and reason for returned funds.
- Return funds using one of the following applicable options:

Send an HPA check (with company name and address):

Make check payable to US Treasury - HCTC.
Complete this form, attach check, and MAIL to:

Internal Revenue Service
Beckley Finance Center PO Box 9002
Beckley WV 25802-9002

Reversal of an EFT transaction:

Notify your bank that you want to reject the EFT, and request that they reverse the transaction back to the US Department of Treasury. Complete this form and FAX to:

Internal Revenue Service - HCTC
FAX #: 855-780-9044

Return an uncashed US Treasury check:

Complete this form, attach check, and MAIL to:

Internal Revenue Service
Beckley Finance Center PO Box 9002
Beckley WV 25802-9002

You can return funds for multiple individuals by using one of the following options: (1) Send a separate check and separate HPA Return of Funds Form, or, you can send an internal document for each individual, or, (2) Send one check as a bulk payment, and attach a detailed list that defines how the bulk payment should be allocated. This list must include all information that is required on the HPA Return of Funds form, for each individual for whom you are returning funds (listed below).

Use one HPA Return of Funds form per insured, completing all sections below. Please mark N/A wherever applicable.

Insured Name: _____ SSN *(last 4 digits)*: _____

Date Coverage Ended: _____ Reason for Termination: _____

Total Amount Returned: _____

Reason for Returned Funds:

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