Sample - QFM

Social Security # from Part 1 of Form _____

Instructions for Form 13441-A

(May 2018)

Health Coverage Tax Credit (HCTC) Monthly Registration and Update

Department of the Treasury
Internal Revenue Service

SAMPLE ONLY - USE A BLANK FORM FOR SUBMISSION TO THE IRS

General Instructions

This is the SSN for the PBGC check recipient

Please read carefully and follow the instructions below to complete Form 13441-A. **Write your Social Security Number at the top of each document** you are sending to the HCTC Program. Print or type your responses. To register for the Monthly HCTC, you must complete the following steps:

1. Collect the documents you will need to submit with your HCTC Monthly Registration and Update form. See the "Required Supporting Documents" section for a detailed list of the required documents.
2. Fill out the HCTC Monthly Registration and Update form.
3. Make a copy of the completed HCTC Monthly Registration and Update form and all required documents for your records.
4. Mail the completed HCTC Monthly Registration and Update form and all required documents to:

   Internal Revenue Service
   Stop 6098 AUSC
   Austin, Texas 78741

   All 13441-A forms are sent to the plan administrator.
   Benistar Retiree Services
   10 Tower Lane, Suite 100
   Avon, CT 06001
   Fax: 1-860-408-7025
   Email: memelig@benistar.com

☒ 5. Check here if you are registering as a Qualified Family Member. Note: Qualified Family members of HCTC eligible individuals may receive the HCTC for up to 24 months following the eligible individual's Medicare enrollment, death or divorce. For more information on Qualified Family Member eligibility, see Form 8885 instructions under Qualified Family Member.

☐ 6. ~~Check here if you are updating your current monthly registration. When you are enrolled in the monthly HCTC Program, you must inform us of all changes that af... your eligi..., your family members and your health insurance cost. You only need to provide the updated ...rmat...~~

~~Note: Please note that once you mail the HCTC Monthly ...tration and Update form, it can take up to 6 weeks *(if all requirements are met)* before you receive registration ...mation. During this time, you must continue to pay 100% of your health insurance bills directly to your hea... pla... d keep records of your payments. You can claim the yearly tax credit for these and any months that y... et all ...bility requirements and made payments directly to a qualified health plan on your federal income ta... turn.~~

Required Supporting Document and Information

The following document is required to be submitted with your HCTC Monthly Registration and Update form. Review the required document checklist carefully. Caution: An incomplete form or missing documents will delay the processing of your registration.

☒ **A copy of your health insurance bill dated within the last 60 days that includes all of the following:**

- Your name
- Monthly premium amount
- Dates of coverage
- Health Plan name and phone number
- Health plan identification numbers
- Address for mailing your payments

If applicable, your bill must show the following:

- Dollar amount for family members who are not qualified for the HCTC
- Separate dollar amount for benefits that the HCTC does not cover *(such as separate dental or vision plans)*

Mail a letter signed by the PBGC pension recipient to Benistar no later than the 1st of the month prior to the PBGC pension recipient becoming Medicare eligible. Include PIN and SSN in this letter. This will key Benistar to cancel the PBGC pension recipient in their system. In the same envelope, include Form 13441-A for the Qualified Family Member (QFM) **AND** include a copy of the QFM's new DSRA-BT BCBSM Enrollment Form .

Usually, your health insurance bill will have all this information on it. If it does not, you will need a letter or another document from your Health Plan that includes this information.

You should confirm with your Health Plan Provider or Third Party Administrator if applicable that they meet the IRS payment requirements through the Direct Deposit Program, including filing Form 3881, ACH Vendor/Miscellaneous Payment Enrollment - HCTC. The IRS requires this in order to make payments on your behalf.

This is the Same Social Security # from Part 1 of Form.

Your SSN _____

Form **13441-A**
(May 2018)

Department of the Treasury - Internal Revenue Service

Health Coverage Tax Credit (HCTC) Monthly Registration and Update

OMB Number
1545-1842

Part 1: Your General Information

PBGC Pensioner - Even if you're over the age of 65

HCTC Eligible Recipient name *(First, Middle Initial, Last, Suffix)*

Social Security Number (SSN)	Date of birth *(mm/dd/yyyy)*	Primary telephone number	Alternate telephone number

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

Part 2: Confirm Your Eligibility

Check the box that applies to you to certify that the statement is true:

[X] The HCTC Eligible Recipient is a PBGC payee and 55 years old or older. PBGC payee is pension check recipient

[ ] The HCTC Eligible Recipient is an eligible Trade Adjustment Assistance (TAA), Alternative TAA (ATAA), or Reemployment TAA (RTAA) recipient.

You will check the box below if you are registering as the HCTC Eligible Recipient or Qualifying Family Member.

Note: Qualified Family members of HCTC eligible individuals may receive the HCTC for up to 24 months following the eligible individual's Medicare enrollment, death or divorce. For more information on Qualified Family Member eligibility, see Form 8885 instructions under Qualified Family Member.

[X] I certify that all of the following statements are true for me and my qualified family members.

- I/we are not enrolled in an Affordable Care Act Marketplace insurance.
- I/we are covered by a qualified health plan for which I pay more than 50% of the premiums.
- I/we are not enrolled in Medicare Part A, B, C, or D.
- I/we are not enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
- I/we are not enrolled in the Federal Employees Health Benefits Program (FEHBP).
- I/we are not enrolled in the U.S. military health system (TRICARE).
- I/we are not imprisoned under federal, state, or local authority.
- I/we are not claimed as a dependent on someone else's federal income tax return.

These statements pertain to the QFM

Part 3: Family Member Information

Complete with QFM Information

If you have more than five (5) qualified family members, make a copy of this page and then complete this section for any additional family members.

Fill out #2 through 5 ONLY if there are additional dependents

_____ Please list the total number of family members *(other than yourself)* you are registering for the Monthly HCTC.

Total includes SQFM & dependents enrolling on same form

[ ] Check the box to certify that the following applies to each family member listed below:

- My family member is my spouse or claimed as a dependent on my federal income tax return and
- My family member meets all general requirements for the HCTC listed in Part 2 *(with the exception of the last bullet)*.

1

Family member's name *(First, Middle Initial, Last, Suffix)*	Social security number (SSN)	Date of birth *(mm/dd/yyyy)*

Relationship to you: [ ] Spouse [ ] Child [ ] Other

Is this person on your health plan? [X] Yes [ ] ~~No. This person has a separate qualified plan. Make a copy of the next page and use Part 4 to provide their health insurance information.~~

X

2

Family member's name *(First, Middle Initial, Last, Suffix)*	Social security number (SSN)	Date of birth *(mm/dd/yyyy)*

Relationship to you: [ ] Spouse [ ] Child [ ] Other

Is this person on your health plan? [X] Yes [ ] ~~No. This person has a separate qualified plan. Make a copy of the next page and use Part 4 to provide their health insurance information.~~

X

This is the Same Social Security # from Part 1 of Form.

Your SSN _____

3	Family member's name *(First, Middle Initial, Last, Suffix)*	Social security number (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you: ☐ Spouse ☐ Child ☐ Other	Is this person on your health plan? ☒ Yes ☐ ~~No. This person has a separate qualified plan. Make a copy of the next page and use Part 4 to provide their health insurance information.~~	
4	Family member's name *(First, Middle Initial, Last, Suffix)*	Social security number (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you: ☐ Spouse ☐ Child ☐ Other	Is this person on your health plan? ☒ Yes ☐ ~~No. This person has a separate qualified plan. Make a copy of the next page and use Part 4 to provide their health insurance information.~~	
5	Family member's name *(First, Middle Initial, Last, Suffix)*	Social security number (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you: ☐ Spouse ☐ Child ☐ Other	Is this person on your health plan? ☒ Yes ☐ ~~No. This person has a separate qualified plan. Make a copy of the next page and use Part 4 to provide their health insurance information.~~	

Part 4: Health Plan Information

Fill out the information below. If your family members are on a separate health plan, make a copy of Part 4 before filling it out to provide their qualified health insurance information.

Note: If you have coverage through your spouse's employer that is not a COBRA plan, stop here. You cannot receive the Monthly HCTC for this type of coverage. You can, however, claim the Yearly HCTC by filing Form 8885 with your federal income tax return.

Complete this section for all coverage types:

Health Plan Provider name: DSRA-BT. VEBA/BCBS Michigan	Effective date of coverage: 1st of the month you intend to enroll in BCBSM plan.	Health plan ID number: 38-2069753

HCTC vendor name *(name of company to be payed on your behalf)*: BESTCO BENEFITS LLC/BENISTAR

HCTC vendor number *(contact your Health Plan Provider or Third Party Administrator)*: 01958486

Provide at least one of the following ID Numbers.

Member ID: ID # on front of BCBSM ID CARD	Group ID: 007023339	~~Policy or plan ID~~ ☒

Policy holder's name *(First, Middle Initial, Last, Suffix)*: QFM Name	Policy holder's SSN: This is the SSN of the QFM

Leave # 3, 4, & 6 BLANK

1. Total Monthly Medical Premium	
2. Total number of people *(you and any family members)* on this policy	
3. Number of family members on this policy who are not qualified for the HCTC	Leave Blank
4. Monthly premium amount for family members who are not qualified for the HCTC *(this amount will be removed from your total monthly medical premium and you will need to pay directly to your HPA/TPA).*	Leave Blank

Provide same 27.5% for #'s 5 & 7

5. Total HCTC Total Monthly Medical Premium *Line (1) minus line (4) and multiplied by 27.5% (.275)*	
6. Other health benefits amount *(vision, dental, non-medical benefits).* This amount will be added to your monthly HCTC payment.	Leave Blank
7. Monthly HCTC payment *Line 5 plus Line 6*	

~~**Complete this section only if you have COBRA coverage:**~~

☐ Check here only if the Health Plan Information in Part 4 is for COBRA Coverage.

~~Former employer~~ ☒	~~Former employer's HR telephone number~~
~~Start Date for COBRA Coverage *(mm/dd/yyyy)*~~	~~End Date for COBRA Coverage *(mm/dd/yyyy)*~~

☐ Check here if this is a Lifetime Benefit.

This is the Same Social Security # from Part 1 of Form.

Your SSN _____

Part 5: Account Accessibility

If you would like to allow someone else – for example, your spouse, family member, or other trusted advisor – to have access to your account information, please complete this page. This person, called a Third-Party-Designee, will be able to ask questions about, or make changes to, your HCTC account or personal information, as appropriate.

Third-Party-Designee

Do you want to allow another person to talk with the HCTC Program about your account?

Only complete this section if you choose to designate another person to allow them to access your account information

☐ Yes. Complete the rest of this page and choose a PIN.

☐ No. Go to Part 6 to sign and date the HCTC Monthly Registration and Update form.

Name of Third-Party-Designee *(First, Middle Initial, Last, Suffix)*

Primary telephone number	Alternate telephone number

Personal Identification Number (PIN)

IMPORTANT! You must choose a PIN when you make someone a Third-Party-Designee. This PIN protects the security of your account information similar to the PIN you use for a bank card. When your Third-Party-Designee calls the HCTC Program, they will be asked to give the PIN to get information about your account. Your Third-Party-Designee can help you choose the PIN so that it is easy to remember.

Note: The PIN must be a five-digit number. If your PIN includes letters and/or non-numeric characters, this could cause a delay in processing your Third-Party-Designee request. Choose a PIN and write it in the space provided.

Personal Identification Number (PIN)

If you select "Yes" above, you **must** enter a PIN Number

Part 6: Form Completion

Review this form to make sure you have completed everything needed for your registration. You must sign and date this form to have your registration for the monthly HCTC program processed. Sign and date in the space provided below.

Signature

Must be signed by the Recipient from Part 1

Under pena…e information furnished on this form with regard to myself and to any family members, and any attachm… complete. I understand that a knowingly and willfully false statement on this form can result in my disqualifi… program. By signing, I authorize the IRS 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

Privacy Act and Paperwork Reduction Act Notice

The Privacy Act of 1974 and 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.

We use the information you submit to determine if you qualify for the monthly credit 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 Yearly HCTC when you file your federal income tax return.

The estimated average time to complete this form is 30 minutes. You are required to provide the information requested on a form that is subject to the Paperwork Reduction Act if 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.