Sample - Address Changes

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 affect your eligibility, your family members and your health insurance cost. You only need to provide the updated information.

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

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)*~~

~~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.

[ ] ~~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.

Part 3: Family Member Information

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

_____ Please list the total number of family m... *(other than yours ...* ...e registering for the Monthly HCTC.

[ ] Check the box to certify that the following applie... family me... ...ed below:

- My family member is my spouse or claimed as a d... ...t on m... ...l income tax return and
- My family member meets all general requirements f... ...CT... ...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 perso... ...r h...? [ ] Yes [ ] ...his pe... ...a separate qualified plan. Make a copy of the next page and use Part ... ...de their health insurance information.	
2	Family member's name *(First, Middle Initial, Las...*	Su... ...rity number (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you [ ] Spouse [ ] Child [ ] Other	Is ... ...on on your health plan? [ ] No. This person has a ... ...qualified plan. Make a copy of the next page and use Part 4 to provid... ...lth insurance information.	

3 (First, Middle Initial, Last, Suffix) | Social security number (SSN) | Date of

Re... | Is this person on your health plan?

☐ S...er ☐ Yes ☐ No. This person has a separate qualified plan. ...age and use Part 4 to provide their health insuran...

4 Family n... Initial, Last, Suffix) | Social security number (SSN) ...yyy)

Relationship ... | s this person on your health plan?

☐ Spouse ☐ ... ☐ Yes ☐ No. This person has a separate qua... the next page and use Part 4 to provide their hea...

5 Family member's na... t, Suffix) | Social security num... th (mm/dd/yyyy)

Relationship to you | on on your health plan?

☐ Spouse ☐ Child ☐ ... ☐ No. This person has a ser... ke a copy of the next page and use Part 4 to provid... information.

Part 4: Health Plan Informati...

Fill out the information below. If your ... separate healt... Part 4 before filling it out to provide their qualified health insurance informa...

Note: If you have coverage through your ... is not a ... e. You cannot receive the Monthly HCTC for this type of coverage. You ... Yea... 8885 with your federal income tax return.

Complete this section for all coverage types:

Health Plan Provider na... | te of coverage | Health plan ID number

HCTC vendor name *(name of ...*

HCTC vendor number *(contact ... Party Administrator)*

Provide at least one of the ...

Member ID | Policy or plan ID

Policy holder's nam... st, Suffi... SN

1. Total Month...
2. Total num... *ny family members)* o...
3. Number... his policy who are not q...
4. Mont... family members who are no... *(this ... om your total monthly medical prem... pa... .*

...nthly Medical Premium *Line (1) minus lin... (.275)*

...efits amount *(vision, dental, non-medical benefits).* Th... our monthly HCTC payment.

... payment *Line 5 plus Line 6*

Complete th... section on... have COR... coverag... only if the Health Plan Information in Part 4 is for COBRA Co...

...yer | Former employer's HI...

...e for COBRA Coverage *(mm/dd/yyyy)* | End Date for COBRA Cove...

...heck here if this is a Lifetime Benefit.

Part 5: Account Accessibility

If you would like to allow someone else – e, your spouse, family memb trusted advisor – to have access to your account information, please complete this p erson, called a Third-Part e, will be able to ask questions about, or make changes to, your HCTC account or pe mation, as appropriate.

Third-Party-Designee

Do you want to allow another person to talk with Program abou unt?

☐ Yes. Complete the rest of this page and choose

☐ No. Go to Part 6 to sign and date the HCTC Mont ation e form.

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

Primary telephone number rnate telephone number

Personal Identification Number (PIN)

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

Note: The PIN must be a five-digit number. If cludes letters and/o eric characters, this could cause a delay in processing your Third-Party-Designee hoose a PIN and write ace provided.

Personal Identification Number (PIN)

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

Under penalties of perjury, I declare that the information furnished on this form with regard to myself and to any family members, and any attachments to it, is true, correct, and complete. I understand that a knowingly and willfully false statement on this form can result in my disqualification from the monthly HCTC 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
Signature	Full Name	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.