

Department of the Treasury Internal Revenue Service

(May 2018) Health Coverage Tax Credit (HCTC) Monthly Registration and Update

Instructions for Form 13441-A

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	All 13441-A forms are sent to the plan administrator.		
Stop 6098 AUSC Austin, Texas 78741	Benistar Retiree Services	Fax: 1-860-408-7025	
Austin, Texas 78741	10 Tower Lane, Suite 100		
	Avon, CT 06001	Email: memelig@benistar.com	

3-5. 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.

X 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:

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

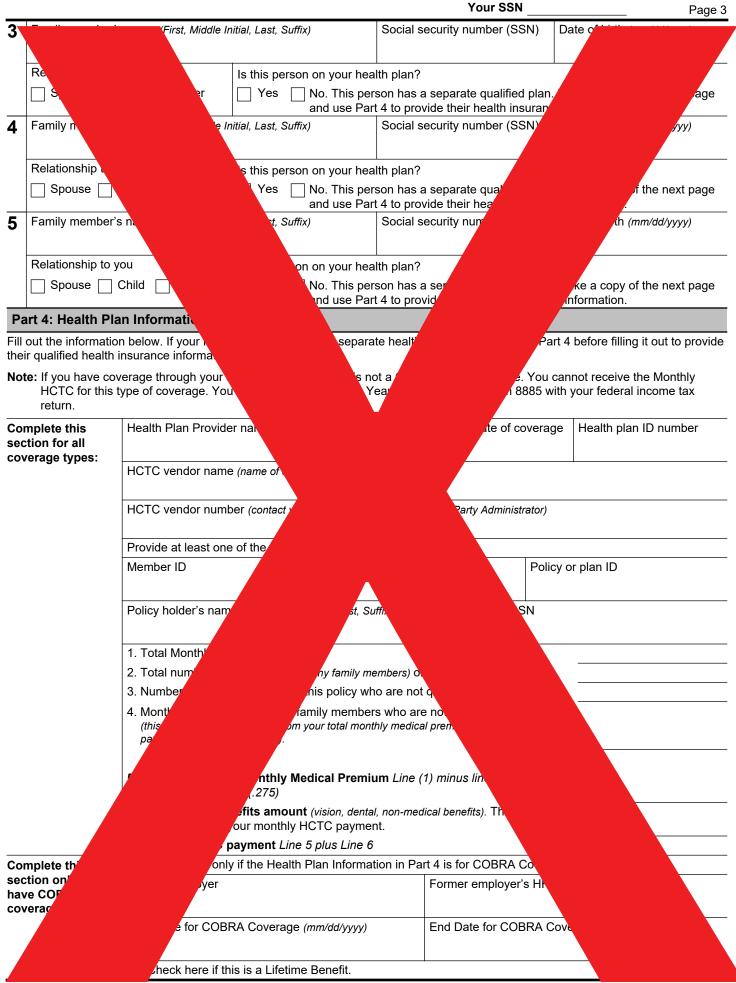
If applicable, your bill must show the following:

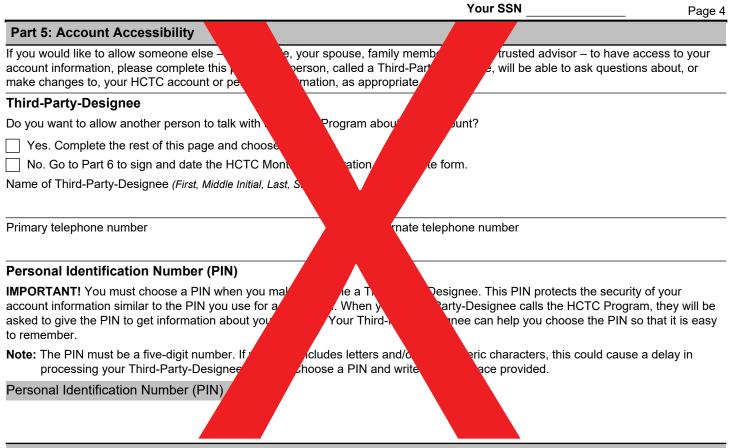
- Dollar amount for family members who are not qualified for the HCTC
- Separate dollar amount for benefits that the HCTC does not cover (such as separate dental or vision plans)

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 Socia from Part 1 of Form.	al Security #	Your SSN	_		
Form 13441-A (May 2018)	Health Cove	rage Tax Cre gistration ar	dit (HCTC)	OMB Nu 1545-1		
Part 1: Your General Inf	formation PBGC Pensio	oner - Even if you're	over the age of	<mark>65</mark>		
HCTC Eligible Recipient nam	ne (First, Middle Initial, Last, Suffi	x)				
Social Security Number (SSI	N) Date of birth (<i>mm/dd/yyy</i>)	y) Primary tele	bhone number	Alternate telephone n	umber	
Mailing Address (Street Numb	er, City, State, ZIP)					
Part 2: Confirm Your El	igibility					
Check the box that applies to	o you to certify that the statem	ent is true:				
X The HCTC Eligible Recip	pient is a PBGC payee and 55	years old or older.				
(RTAA) recipient.	bient is an eligible Trade Adju ∕ if you are registering as the I	·			n t TAA-	
Note: Qualified Family memi individual's Medicare of instructions under Qua	enrollment, death or divorce. I					
x I certify that all of the foll	owing statements are true for	me and my qualified fa	mily members.			
 I/we are covered by a quantum of the second secon	an Affordable Care Act Marke ualified health plan for which I Medicare Part A, B, C, or D. Medicaid or the Children's He the Federal Employees Health the U.S. military health systen under federal, state, or local a a dependent on someone els	pay more than 50% of alth Insurance Program n Benefits Program (FE n (TRICARE). authority.	(CHIP). HBP).			
Part 3: Family Member	Informatio					
If you have more than five (5 family members.		ake a copy of this pa	en complete ti	nis section for any add	itional	
Please list the tot	al number of family n	other than yours	e registering for the	Monthly HCTC.		
Check the box to certify t	that the following applie	family me	d below:			
• My family member is my			come tax return and			
• My family member meet	ts all general requirements fu	T in Par	t 2 (with the exception of	of the last bullet).		
1 Family member's name	(First, Middle Initial, Last, Suffix)	Social sec	urity number (SSN)	Date of birth (mm/dd/)	/ууу)	
Relationship to you	Other Is this perso	use Part d	e their health insuran			
2 Family member's name	(First, Middle Initial, Las	S	rity number (SSN)	Date of birth (mm/dd/)	(ууу)	
Relationship to you Is not your health plan?						
Spouse Child	Other	No. This person has a and use Part 4 to provid		. Make a copy of the n ce information.	ext page	
Catalog Number 57559E		www.irs.gov		Form 13441-A (F	Rev. 5-2018)	





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.

	aperwork Reduction Act Notice	Date
Signature	Full Name	Date
Signature	Full name (print)	Date

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.