Form **14117** (Rev. October 2012)	Department of the Treasury–**Internal Revenue Service** **HCTC Family Member Registration**	**OMB Number 1545-2162**

Family members of Pension Benefit Guaranty Corporation (PBGC) payees or Trade Adjustment Assistance (TAA) - including RTAA recipients, can receive the Health Coverage Tax Credit (HCTC) for up to 24 months from the month the PBGC payee or TAA recipient enrolls in Medicare, or until January 1, 2014, whichever comes first. If you are a PBGC payee or TAA recipient, complete this form to receive the Monthly HCTC for the premiums of your qualified family members. *Please note that the Trade Adjustment Assistance Extension Act of 2011, which authorizes this extension of HCTC eligibility for your family members, expires on January 1, 2014.*

Instructions:

1. Print or type your responses.
2. Sign and date this form.
3. Keep a copy of this completed form and all required supporting documents for your personal records.
4. **DO NOT SEND PAYMENT WITH THIS FORM.** Mail the completed form and supporting documents to:

HCTC Processing Center
P.O. Box 760189
San Antonio, TX 78245

Part 1: Provide information about you

Name *(First, Middle Initial, Last, Suffix)*	Gender ☐ Male ☐ Female
Social Security Number *(SSN)*	Date of Birth *(mm/dd/yyyy)*
Mailing Address *(Street Number)*	City, State, ZIP
Primary Phone Number	Date Enrolled in Medicare

Part 2: Provide information about your family member(s)

If you have more than one qualified family member, make a copy of this page and complete it for any additional family members.

Family Member's Name *(First, Middle Initial, Last, Suffix)*		Relationship to You: ☐ Spouse ☐ Child ☐ Other
Social Security Number *(SSN)*	Date of Birth *(mm/dd/yyyy)*	Gender ☐ Male ☐ Female

Would you like for this individual to be added as your Third-Party-Designee on your account? ☐ Yes ☐ No

If yes, choose a Personal Identification Number (PIN). The PIN must be a five-digit ***number.*** ☐☐☐☐☐

Your Third-Party-Designee will be asked to provide the PIN number you establish above, in order to ask questions about, or make changes to, your HCTC account or personal information.

Part 3: Confirm that the following statements are true

Check all boxes that apply. I certify that I am:

- ☐ Enrolled in Medicare, and I am completing this form to register my HCTC-qualified family members only.
- ☐ A TAA, Alternative TAA, or Re-employment TAA recipient, **or** a Pension Benefit Guaranty Corporation (PBGC) payee and am 55 years old or older.
- ☐ Not claimed as a dependent on anyone's federal income tax return.

Check all boxes that apply. I certify that **my family member(s) and I:**

- ☐ Can **not** receive health coverage through the U.S. military health system (TRICARE).
- ☐ Are **not** enrolled in the Children's Health Insurance Program (CHIP) or the Federal Employees Health Benefits Program (FEHBP).
- ☐ Are **not** in prison.
- ☐ Are **not** covered by any health insurance plan where a former employer, or spouse's employer, pays 50% or more of the premiums.

Check all boxes that apply. I certify that **my family member(s):**

- ☐ Is covered by a qualified health insurance plan.
- ☐ Is **not** enrolled in Medicare Part A, B, or C.
- ☐ Is my spouse or is claimed as a dependent(s) on my federal income tax return.

Part 4: Provide health plan information about your family member(s)

Fill out the information below for your family member(s). If your family members have a separate health plan(s), make a copy of this page before filling it out to provide their qualified health insurance information.

Check the box that applies:

☐ Although enrolled in Medicare, I am covered by the insurance plan listed below.

☐ I am not covered by the plan listed below.

Please complete this section.	Type of Coverage: ☐ COBRA ☐ State-qualified ☐ VEBA ☐ Non-group/individual			
	Health Plan Name	Health Plan ID Number	Effective Date of Coverage	
	Please provide at least one of the following ID Numbers.			
	Member ID	Group ID	Policy or Plan ID	
	Policyholder's name *(First, Middle Initial, Last, Suffix)*	Policyholder's SSN	Total monthly premium	
	Total number of people (you and any family members) on this policy			
	Number of family members on this policy who are not qualified for the HCTC			
	Portion of monthly premium for family members who are not qualified for the HCTC			
	Portion of monthly premium that covers a separate dental or vision plan			
Complete this section only if you have COBRA coverage.*	Your Former Employer	Former Employer's HR Phone Number		
	Start Date for COBRA Coverage *(mm/dd/yy)*	End Date for COBRA Coverage *(mm/dd/yy)* ☐ Check here if Lifetime Benefit		
Complete this section only if you have non-group/individual coverage.*	Employer that Made You Eligible for PBGC or TAA Benefits	Employer's Phone Number		
	Your Last Paid Day of Work for that Employer	Start Date of Non-Group/Individual Insurance		

**If you have this type of health plan, additional supporting documents are required. Visit www.irs.gov/hctc. Click the link for "Monthly HCTC."*

Part 5: Gather supporting documents

Please send us:

A copy of your family's health insurance bill dated within the last 60 days. Make sure it has all of the following information:

- Your name
- Name and phone number of your health plan or administrator, the address for mailing your payments, and health plan identification number(s)
- Monthly premium amount, monthly premium due date, and dates of coverage

If necessary, your bill must show the following:

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

Note: *Usually your health insurance bill will have all this information on it. If it doesn't, you must give us a letter from your health plan with this information on it. If you have COBRA or non-group/individual coverage, you will need to provide additional supporting documents that can be found on www.irs.gov/hctc .*

If you have any questions about this form, please contact the HCTC Customer Contact Center toll-free at 1-866-628-HCTC (4282). For those with a hearing impairment, call 1-866-626-4282 (TTY).

Part 6: Sign and date this form

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**

PAPERWORK REDUCTION ACT NOTICE. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Your response is voluntary. You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless 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 become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by code section 6103. The estimated average time to complete this form is 15 minutes. If you have comments concerning the accuracy of this time estimate or suggestions for making this form simpler, we will be happy to hear from you. You can write to the Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, Washington, DC 20224.

PRIVACY ACT STATEMENT. The following information is provided to comply with the Privacy Act of 1974 (P.L.93-579). All information collected on this form is required under the provisions of 31 U.S.C. 3322 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data, by electronic means to vendor's financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the Automated Clearing House Payment System.