Form **13704** (Rev. April 2012)	Department of the Treasury– **Internal Revenue Service** **HCTC MONTHLY REGISTRATION UPDATE**	**OMB Number 1545-1954**

Use this form to make updates to your monthly Health Coverage Tax Credit (HCTC) account. When you or your family members 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. If you do not keep your HCTC account information current, you could risk losing the Monthly HCTC.

Instructions:

1. **Keep a blank copy** of this form in your personal records for future use. This form can also be found at www.irs.gov/hctc.
2. Only use this form if you need to make **changes** to your HCTC account.
3. **Print or type** your responses. Leave blank any box that does not apply to you or your family members.
4. You must complete Part 5.
5. You must sign and date this form to confirm your continued eligibility for the HCTC.
6. Keep a copy of this completed Registration Update Form—and all required supporting documents—for your personal records.
7. **DO NOT SEND PAYMENT WITH THIS FORM.** Mail the completed form and required supporting documents to:

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

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 1: Provide information about you

Name *(First, Middle Initial, Last, Suffix)*			Gender ☐ Male ☐ Female
Social Security Number *(SSN)*	Date of Birth *(mm/dd/yyyy)*	Primary Phone Number	Check here if address or phone has changed ☐

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

Note: You must also provide mailing address changes to the agency that reports you as eligible for the HCTC Program. This is either your state (unemployment office) or the Pension Benefit Guaranty Corporation (PBGC).

Part 2: Confirm your eligibility

Check the box below to confirm your eligibility for the HCTC.

☐ I certify that ***all*** of the following statements are true.

- I am an eligible Trade Adjustment Assistance (TAA), Alternative TAA (ATAA), or Reemployment TAA (RTAA) recipient; a Pension Benefit Guaranty Corporation (PBGC) payee; OR I am a qualified family member of a PBGC payee or TAA recipient who has passed away or from whom I have finalized a divorce.
- I am covered by a qualified health plan for which I pay more than 50% of the premiums. (An employer does not pay 50% or more of my premiums.)
- I am not enrolled in Medicare Part A, B, or C; OR I am enrolled in Medicare but only claiming premiums for my qualified family members.
- I am not enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
- I am not enrolled in the Federal Employees Health Benefits Program (FEHBP).
- I am not enrolled in the U.S. military health system (TRICARE).
- I am not imprisoned under federal, state, or local authority.
- I am not claimed as a dependent on someone else's federal income tax return.

If you do not certify all of the statements above, you are no longer eligible to receive the HCTC. You should submit this form and select "Cancel my Registration" in Part 3 or call the HCTC Customer Contact Center to tell us about this change.

Part 3: Tell us what to change on your HCTC account

Check all that apply.	*Effective Date of Change (mm/dd/yyyy)*
☐ Add or remove a family member.	
☐ Change information about my or my family member's current health insurance (e.g., change in premium amount, change in any ID numbers, change in address where payments are currently sent).	
☐ The administrator for my COBRA coverage has changed (COBRA only).	
☐ I or my family member(s) have *new* HCTC qualified health insurance.	
☐ Switch my eligibility type from TAA (or ATAA/RTAA) to PBGC.	
☐ Reactivate my HCTC account. *Select the option which applies.* I have been enrolled within the last: ☐ 30 days and no changes have been made to my health coverage *(No Supporting Documents Required)* ☐ 30 – 90 days or there have been changes to my health coverage *(Supporting Documents Required)*	
☐ Cancel my Registration. I no longer wish to participate in the Monthly HCTC.	

Explain the reason for your update.

Part 4: Provide information for your family member changes

Please check the box that applies:
- ☐ Add eligible family member
- ☐ Remove ineligible family member

If you are changing the information for more than one qualified family member, make a copy of this page before filling it out.

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

Is this person on your health plan? ☐ **Yes** ☐ **No** This person has a separate qualified plan. Make a copy of this page and use Part 5 to provide their health insurance information.

Part 5: Provide information about your qualified health insurance

Part 5 is required. You must submit proof of insurance (e.g., a current bill) and any other required documents for the health insurance policy you describe below. For detailed information on the supporting documents you must submit, visit www.irs.gov/hctc.

Please complete this section.

Type of Coverage: ☐ COBRA ☐ State-qualified ☐ VEBA ☐ Non-group/individual

Health Plan Name	
Effective Date of Coverage	Health Plan ID Number

Please provide at least one of the following ID Numbers.

Member ID	Group ID	Policy or Plan ID

Policy Holder's Name *(First, Middle Initial, Last, Suffix)*	Policy Holder'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.*

Former Employer	Former Employer's HR Phone 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

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. For a list of the supporting documents visit www.irs.gov/hctc and click the "Monthly HCTC" link.*

Part 6: Sign and date this form to confirm your HCTC eligibility

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.