

Form 14095 (Rev. February 2010)	Department of the Treasury—Internal Revenue Service The Health Coverage Tax Credit (HCTC) Reimbursement Request	OMB No. 1545-2152
---	---	-------------------

Part 1: Provide information about yourself

Name (<i>first, middle initial, last, suffix</i>)	Social Security Number
Mailing Address (<i>street number</i>)	City, State, Zip
Primary Telephone Number (<i>include area code</i>)	

Part 2: Request reimbursement

Check the box next to each month of this calendar year for which you are requesting reimbursement. For each month checked, you certify that you 1) met **all** eligibility requirements for the HCTC and 2) that you made payments directly to a qualified health plan for that month.

- ☐ January ☐ February ☐ March ☐ April ☐ May ☐ June
☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

In the tables below, enter the information requested for **EACH MONTH** checked above. If you are requesting reimbursement for more than two months, copy this form and complete Part 2 for those additional months.

Month and year for which you are requesting reimbursement.		Month	Year
1	Total monthly premium amount you paid directly to your qualified health plan (for yourself and your family members).		
2	Amount you paid for separate dental or vision benefits . These benefits do not qualify for the HCTC.		
3	Amount you paid for family members who are not qualified for the HCTC, including yourself if you are enrolled in Medicare.		
4	Amount of National Emergency Grant (NEG) payments received.		

Month and year for which you are requesting reimbursement.		Month	Year
1	Total monthly premium amount you paid directly to your qualified health plan (for yourself and your family members).		
2	Amount you paid for separate dental or vision benefits . These benefits do not qualify for the HCTC.		
3	Amount you paid for family members who are not qualified for the HCTC, including yourself if you are enrolled in Medicare.		
4	Amount of National Emergency Grant (NEG) payments received.		

Part 3: Provide information about your qualified health insurance

Check the box below that applies to the months for which you've requested reimbursement:

- ☐ I certify that the health plan for this reimbursement request is the same as the qualified health plan listed on my Monthly HCTC Registration.
☐ The health plan for this reimbursement request is different from the qualified health plan listed on my Monthly HCTC Registration. If so, complete Part 5 of the HCTC Registration Update Form (13704) and attach it to this form. This form can be obtained by going to www.irs.gov/hctc.

Part 4: Gather supporting documents

Include copies of 1) health insurance bills or payment coupons and 2) proof of payment for the months in Part 2 of this form.

1) Your health insurance bills or payment coupons must show the following information:

- Your name (or name of the policy holder)
- Name of your health plan
- Your monthly premium amount
- Dates of coverage
- Your health plan identification number

Note: If your qualified health plan does not provide members with an insurance bill or COBRA payment coupon, you must provide health plan enrollment documents or an official letter from your health plan that has the required information listed in the bullets above.

2) Acceptable proof of payment includes:

- Cancelled checks (copy of front and back)
- Bank statements
- Credit card statements
- Money order receipts

Note: Your proof of payment must indicate the amount paid and to whom it was paid. If you do not have one of these proofs of payment, contact your health plan for a record of your payment(s).

Part 5: 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 also agree to allow the IRS to share my eligibility status and payment information with my health plan.

Signature	Full Name (print)	Date