Instructions for Form 13441-A

(December 2011)

Health Coverage Tax Credit (HCTC) Monthly Registration

Department of the Treasury
Internal Revenue Service
IRS

General Instructions

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 Form. **See the "Required Supporting Documents"** section for a detailed list of the required documents.
2. Fill out the HCTC Monthly Registration Form.
3. Make a copy of the completed HCTC Monthly Registration Form and all required documents for your records.
4. Mail the completed HCTC Monthly Registration Form and all required documents to:

   HCTC Processing Center
   P.O. Box 760189
   San Antonio, TX 78245
5. Please note that once you mail the registration form, it can take four to six weeks before you receive your first HCTC invoice. During this time, you must continue to pay 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.

Required Supporting Documents

The following documents are required to be submitted with your HCTC Monthly Registration Form. Review the required documents 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
- Monthly premium due date
- Dates of coverage
- Health Plan Administrator 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 Administrator that includes this information.

If you have COBRA, you also must send ONE of these documents:

☐ A copy of your completed and signed COBRA Election Letter (it could also be called a COBRA Enrollment Form, Application Form, Enrollment Application for Continuing Coverage, or Election Agreement).

☐ A letter from your former employer or COBRA administrator stating you have COBRA coverage that includes:

- Your COBRA start and end dates
- Your home address
- Health Plan name
- Covered family members, their dates of birth, their relationship to you, and their Social Security Numbers

☐ A copy of the "Notice of Rights to Continue Coverage" and proof you have paid your bill. You can use a cancelled check or a credit card/bank statement dated within the past 60 days as proof.

If you have non-group/individual coverage, you also must send:

☐ A letter or other document from your former employer or your unemployment office that shows the day you left your job, *and*

☐ A document from your health plan that shows your first day of coverage. Remember, your first day of coverage in a non-group/individual health plan must have been at least 30 days before your last day of paid work with the company that made you eligible for PBGC or TAA benefits.

If you have any questions, visit www.irs.gov/hctc or call the HCTC Customer Contact Center toll-free at 1-866-628-HCTC (4282). If you have a hearing impairment, call 1-866-626-4282 (TTY).

Form **13441-A** (Rev. December 2011)	Department of the Treasury–**Internal Revenue Service** **Health Coverage Tax Credit (HCTC)** **Monthly Registration**	**OMB Number 1545-1842**

Part 1: Your General Information

Name *(First, Middle Initial, Last, Suffix)*			Gender ☐ Male ☐ Female
Social Security Number *(SSN)*	Date of Birth *(mm/dd/yyyy)*	Primary Phone Number	Alternate Phone 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:

☐ I am a PBGC payee and 55 years old or older.

☐ I am an eligible Trade Adjustment Assistance (TAA), Alternative TAA (ATAA), or Reemployment TAA (RTAA) recipient.

☐ I am a qualified family member of an individual who fell under one of the categories listed above at the time of death or divorce.*

*If you are registering your qualified family members due to your enrollment in Medicare, do NOT complete this form. You need to complete Form 14117, *HCTC Family Member Registration Form*, available on www.irs.gov/hctc.

Check the box to certify that you meet ***all*** general requirements listed below.

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

- I am covered by a qualified health plan for which I pay more than 50% of the premiums.
- I am not enrolled in Medicare Part A, B, or C.
- 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.

Part 3: Family Member Information

If you have more than three (3) qualified family members, make a copy of this page and then complete this section for any additional family members.

____ Please list the total number of family members (other than yourself) you are registering for the Monthly HCTC.

☐ Check the box to certify that the following applies to each family member listed below:

- My family member is my spouse or claimed as a dependent on my federal income tax return **and**
- My family member meets all general requirements for the HCTC listed in Part 2 (with the exception of the last bullet).

1	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 the next page and use Part 4 to provide their health insurance information.	
2	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 the next page and use Part 4 to provide their health insurance information.	
3	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 the next page and use Part 4 to provide their health insurance information.	

Part 4: Health Plan Information

Please fill out the information below. If your family members are on a separate health plan, make a copy of Part 4 before filling it out to provide their qualified health insurance information.

***Note**: If you have coverage through your spouse's employer that is not a COBRA plan, stop here. You cannot receive the Monthly HCTC for this type of coverage. You can, however, claim the Yearly HCTC by filing Form 8885 with your federal income tax return.*

Complete this section for all coverage types:	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			
	Monthly premium amount 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		

Part 5: Account Accessibility

If you would like to allow someone else – for example, your spouse, family member, or other trusted advisor – to have access to your account information, please complete this page. This person, called a **Third-Party-Designee**, will be able to ask questions about, or make changes to, your HCTC account or personal information, as appropriate.

Third-Party-Designee

Do you want to allow another person to talk with the HCTC Program about your account?

☐ Yes Please complete the rest of this page and choose a PIN.

☐ No Go to Part 6 to sign and date the HCTC Monthly Registration Form.

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

Primary Phone Number	Alternate Phone Number

Personal Identification Number (PIN)

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

Note: The PIN must be a five-digit *number*. If your PIN includes letters and/or non-numeric characters, this could cause a delay in processing your Third-Party-Designee request. Choose a PIN and write it in the space 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 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

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.

Please keep a copy of this notice for your records. It may help you if we later ask you for other information. If you have any questions about the rules for filing and giving information, please call the HCTC Customer Contact Center at 1-866-628-HCTC (4282). TDD/TTY callers, please call 1-866-626-4282.

If you have any comments concerning the accuracy of the time estimate to complete this form or suggestions to make this form simpler, we would be happy to hear from you. You can write to the Tax Forms Committee, Western Area Distribution Center, Rancho Cordova, CA 95743-0001. DO NOT send the form to this office.