Instructions for Form 13441-A

Department of the Treasury

Internal Revenue Service

Retiree Name & SSN ___________________

Enrollee Name & SSN

(Rev. January 2016)

Health Coverage Tax Credit (HCTC) Monthly Registration and Update

Retiree Only Sample for January 2017

You Must Complete **ALL** Required Areas of this Form to Enroll in HCTC Monthly Insurance Program

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.

   Examples: Copy of IRS 1099-R, Paycheck Stub from PBGC, Other document showing PBGC Check

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:

   Internal Revenue Service
   Stop 6[illegible] USC
   Austin, Texas 78741

   Do Not Mail to IRS!
   Fax:1-860-408-7025 or
   Mail: Benistar Service Center
   10 Tower Lane Suite 100 Avon, CT 06001

☐ 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 [illegible] following the eligible individual’s Medicare enrollment, death or divorce.

☐ 6. Check here if you are updating your current mo[illegible] registration. When you are enrolled in the monthly HCTC Program, you must inform us of all changes tha[illegible] your eligibility, your family members and your health insurance. You only need to provide the updat[illegible]ation.

7. Please note that once you mail the registration form, it can take up to 6 weeks *(if all requirements are met)* before you receive registration confirmation. During this tim[illegible] must continue to pay your health insurance bills directly to your health plan and keep records of your paym[illegible] 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 Document

These instructions have been covered at top of page

The following document is required to be submitted with your HCTC Monthly Registration Form. Review the required document checklist carefully. [illegible]ution: An incomplete form or missi[illegible] documents will delay the processing of your registration.

☐ **A copy of your heal[illegible]d withi[illegible]hat includes all of the following:**

- Your name • Healt[illegible]e number
- Monthly premium amoun[illegible]ation numbers • Dates of coverage • Address for mailing your payments

If applicable, yo[illegible]

- Dollar amoun[illegible]bers who are no[illegible]e HCTC
- Separate dollar [illegible]or benefits that the HCTC [illegible] 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.

Retiree Name SSN ____________________
Enrollee Name____________________

Form **13441-A** (January 2016)

Department of the Treasury - Internal Revenue Service

Health Coverage Tax Credit (HCTC) Monthly Registration

OMB Number 1545-1842

Part 1: Your General Information

HCTC/TAA Eligible Recipient to Complete

Name *(First, Middle Initial, Last, Suffix)*

Social security number (SSN)	Date of birth *(mm/dd/yyyy)*	Primary telephone number	Alternate telephone number

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

Part 2: Confirm Your Eligibility

Retiree or TAA Recipient Completes Box 1 or 2. Qualified Family Members (QFM) Completes Box 3

Check the box that applies to you to certify that the statement is true:

(1) ☒ I am a PBGC payee and 55 years old or older.

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

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

Qualified Family Member(s) Completes Box 3

☒ (3) I certify that all of the following statements are true for me and my qualified family members.

- I/we are not enrolled in Marketplace insurance. — Marketplace is Affordable Care Act (ACA)
- I/we are covered by a qualified health plan for which I pay more than 50% of the premiums.
- I/we are not enrolled in Medicare Part A, B, or C.
- I/we are not enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
- I/we are not enrolled in the Federal Employees Health Benefits Program (FEHBP).
- I/we are not enrolled in the U.S. military health system (TRICARE).
- I/we are not imprisoned under federal, state, or local authority.
- I/we are 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 dep[illegible] on my federal [illegible] tax return and
- My family member meets all general requiremen[illegible] listed [illegible]*he exception of the last bullet).*

	Family member's name *(First, Middle Initial, Last, Suffix)*		Social security number (SSN)	Date of birth *(mm/dd/yyyy)*
1	Family member's name *(First, Middle Initial, Last, S*[illegible]		[illegible]ber (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you ☐ Spouse ☐ Child ☐ Other	Is this person o[illegible] ☐ ☐ Y[illegible] [illegible]as a separate qualified plan. Make a copy of the next [illegible] [illegible]vide their health insurance information.		
2	Family member's name *(First, Middle Initial, Last, Suff*[illegible]		[illegible]umber (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you ☐ Spouse ☐ Child ☐ Other	Is this p[illegible] ☐ ☐ [illegible]. This per[illegible] [illegible]eparate qualified plan. Make a copy of the next [illegible] and use Part 4 [illegible]vide their health insurance information.		
3	Family member's name *(First, Middle Initial, Last, Suffix)*		Social security number (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you ☐ Spouse ☐ Child ☐ Other	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.		

Name & SSN ___________________

Part 4: Health Plan Information

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	Health plan name Blue Cross Blue Shield of Michigan	Effective date of coverage	Health plan ID number **Plan Administrator Provides**
	Provide at least one of the following ID Numbers.		
	Member ID	Group ID **Plan Administrator Provides**	Policy or plan ID
	Policy holder's name *(First, Middle Initial, Last, Suffix)*	Policy holder's SSN	Total monthly premium $
	1. Total number of people *(you and any family members)* on this policy		1
	2. Number of family members on this policy who are not qualified for the HCTC		N/A
	3. Monthly premium amount for family members who are not qualified for the HCTC		N/A
	4. Other health benefits amount		N/A
	5. Total HCTC *Total monthly premium minus line (3) and multiplied by 27.5% (.275)*		$0.00
	6. Monthly HCTC payment *Line 4 plus Line 5*		$0.00
Complete this section only if you have COBRA coverage:	Former employer	Former employer's HR telephone 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.		

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. Complete the rest of this page and choose a PIN.

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

This section is optional, you can complete it, if you choose

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

Primary telephone number	Alternate telephone 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)

HCTC Registration form, BCBSM Enrollment Form & Supporting Documents will be mailed, emailed, or faxed to Benistar, NOT the HCTC

SSN ________________________

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.

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.

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Instructions for Form 13441-A Department of the Treasury

Retiree Name & SSN ____________________

Enrollee Name & SSN

I

nternal Revenue Service

(Rev. January 2016)

Health Coverage Tax Credit (HCTC) Monthly Registration and Update

Single Only Sample for January 2017

You Must Complete **ALL** Required Areas of this Form to Enroll in HCTC Monthly Insurance Program

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.

   Examples: Copy of IRS 1099-R,
   Paycheck Stub from PBGC
   Other document showing PBGC Check

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:

   Intern l Rev nue Service
   Stop 6 USC
   Austin, Texa 78741

   Do Not Mail to IRS!
   Fax:1-860-408-7025 or
   Mail: Benistar Service Center
   10 Tower Lane Suite 100 Avon, CT 06001

☐ 5. Check here if you are registering as a Qualified F mil Member. Note: Qualified Family members of HCTC eligible individuals may receive the HCTC for up to 24 m s following the eligible individual's Medicare enrollment, death or divorce.

☐ 6. Check here if you are updating your current mo ly r gistration. When you are enrolled in the monthly HCTC Program, you must inform us of all changes tha t your eligibility, your family members and your health insurance. You only need to provide the updat ation.

7. Please note that once you mail the registration form it can take up to 6 weeks *(if all requirements are met)* before you receive registration confirmation. During this tim must continue to pay your health insurance bills directly to your health plan and keep records of your paym ou 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 Document

These instructions have been covered at top of page

The following document is required to be submitted with your HCTC Monthly Registration Form. Review the required document checklist carefully ution: An incomplete form or missi ocuments will delay the processing of your registration.

☐ **A copy of your healt d withi hat includes all of the following:**

- Your name • Healt e number
- Monthly premium amoun ation numbers • Dates of coverage • Address for mailing your payments

If applicable, yo

- Dollar amoun bers who are no e HCTC
- Separate dollar or benefits that the HCTC 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.

Retiree Name SSN ______________________
Enrollee Name______________________

Form **13441-A** (January 2016)

Department of the Treasury - Internal Revenue Service

Health Coverage Tax Credit (HCTC) Monthly Registration

OMB Number 1545-1842

Part 1: Your General Information

HCTC/TAA Eligible Recipient to Complete

Name *(First, Middle Initial, Last, Suffix)*

Social security number (SSN)	Date of birth *(mm/dd/yyyy)*	Primary telephone number	Alternate telephone number

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

Part 2: Confirm Your Eligibility

Retiree or TAA Recipient Completes Box 1 or 2, Qualified Family Members (QFM) Completes Box 3

Check the box that applies to you to certify that the statement is true:

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

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

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

Qualified Family Member(s) Completes Box 3

(3) ☐ I certify that all of the following statements are true for me and my qualified family members.

- I/we are not enrolled in Marketplace insurance.

Marketplace is Affordable Care Act (ACA)

- I/we are covered by a qualified health plan for which I pay more than 50% of the premiums.
- I/we are not enrolled in Medicare Part A, B, or C.
- I/we are not enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
- I/we are not enrolled in the Federal Employees Health Benefits Program (FEHBP).
- I/we are not enrolled in the U.S. military health system (TRICARE).
- I/we are not imprisoned under federal, state, or local authority.
- I/we are 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 de[illegible] on my federa[illegible] tax return and
- My family member meets all general requiremen[illegible] listed [illegible]he exception of the last bullet).

1 Family member's name *(First, Middle Initial, Last, S[illegible]* | [illegible]ber (SSN) | Date of birth *(mm/dd/yyyy)*

Relationship to you: ☐ Spouse ☐ Child ☐ Other

Is this person o[illegible]: ☐ ☐ Y[illegible] [illegible]as a separate qualified plan. Make a copy of the next [illegible] [illegible]vide their health insurance information.

2 Family member's name *(First, Middle Initial, Last, Suff[illegible]* | [illegible]umber (SSN) | Date of birth *(mm/dd/yyyy)*

Relationship to you: ☐ Spouse ☐ Child ☐ Other

Is this p[illegible]: ☐ ☐ [illegible]. This pe[illegible] [illegible]eparate qualified plan. Make a copy of the next [illegible] and use Part 4 [illegible]vide their health insurance information.

3 Family member's name *(First, Middle Initial, Last, Suffix)* | Social security number (SSN) | Date of birth *(mm/dd/yyyy)*

Relationship to you: ☐ Spouse ☐ Child ☐ Other

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.

Name & SSN ____________________

Part 4: Health Plan Information

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

Health plan name	Effective date of coverage	Health plan ID number
Blue Cross Blue Shield of Michigan		**Plan Administrator Provides**

Provide at least one of the following ID Numbers.

Member ID	Group ID	Policy or plan ID
Plan Administrator Provides		

Policy holder's name *(First, Middle Initial, Last, Suffix)*	Policy holder's SSN	Total monthly premium $

1. Total number of people *(you and any family members)* on this policy — **1**
2. Number of family members on this policy who are not qualified for the HCTC — **N/A**
3. Monthly premium amount for family members who are not qualified for the HCTC — **N/A**
4. Other health benefits amount — **N/A**
5. **Total HCTC** *Total monthly premium minus line (3) and multiplied by 27.5% (.275)* — **$0.00**
6. **Monthly HCTC payment** *Line 4 plus Line 5* — **$0.00**

Complete this section only if you have COBRA coverage:

Former employer	Former employer's HR telephone 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.

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. Complete the rest of this page and choose a PIN.

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

This section is optional, you can complete it, if you choose

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

Primary telephone number	Alternate telephone 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.

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HCTC Registration form, BCBSM Enrollment Form & Supporting Documents will be mailed, emailed, or faxed to Benistar, NOT the HCTC

SSN ________________________

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.

Signature	Full name *(print)*	Date

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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.

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Instructions for Form 13441-A Department of the Treasury

Retiree Name & SSN ___________________
Enrollee Name & SSN

Internal Revenue Service

(Rev. January 2016)

Health Coverage Tax Credit (HCTC) Monthly Registration and Update

Family Sample (3 or more) for January 2017

You Must Complete **ALL** Required Areas of this Form to Enroll in HCTC Monthly Insurance Program

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:

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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:

   Interna[illegible] Rev[illegible]nue Service
   Stop 6[illegible] USC
   Austin, [illegible] 78741

   Do Not Mail to IRS!
   Fax:1-860-408-7025 or
   Mail: Benistar Service Center
   10 Tower Lane Suite 100 Avon, CT 06001

☐ 5. Check here if you are registering as a Qualified [illegible] Member. Note: Qualified Family members of HCTC eligible individuals may receive the HCTC for up to 24 [illegible] following the eligible individual's Medicare enrollment, death or divorce.

☐ 6. Check here if you are updating your current mo[illegible] [illegible]istration. When you are enrolled in the monthly HCTC Program, you must inform us of all changes tha[illegible] your eligibility, your family members and your health insurance. You only need to provide the updat[illegible] [illegible]ation.

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- Monthly premium amoun[illegible] ation numbers • Dates of coverage • Address for mailing your payments

If applicable, y[illegible]

- Dollar amoun[illegible] bers who are no[illegible] e HCTC
- Separate dollar [illegible] or benefits that the HCTC [illegible] cover *(such as separate dental or vision plans)*

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Enrollee Name______________________

Form **13441-A** (January 2016)

Department of the Treasury - Internal Revenue Service

Health Coverage Tax Credit (HCTC) Monthly Registration

OMB Number 1545-1842

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HCTC/TAA Eligible Recipient to Complete

Name *(First, Middle Initial, Last, Suffix)*

Social security number (SSN)	Date of birth *(mm/dd/yyyy)*	Primary telephone number	Alternate telephone number

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

Part 2: Confirm Your Eligibility

Retiree or TAA Recipient Completes Box 1 or 2, Qualified Family Members (QFM) Completes Box 3

Check the box that applies to you to certify that the statement is true:

(1) __ I am a PBGC payee and 55 years old or older.

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

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

Qualified Family Member(s) Completes Box 3

(3) ☐ I certify that all of the following statements are true for me and my qualified family members.

- I/we are not enrolled in Marketplace insurance.

Marketplace is Affordable Care Act (ACA)

- I/we are covered by a qualified health plan for which I pay more than 50% of the premiums.
- I/we are not enrolled in Medicare Part A, B, or C.
- I/we are not enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
- I/we are not enrolled in the Federal Employees Health Benefits Program (FEHBP).
- I/we are not enrolled in the U.S. military health system (TRICARE).
- I/we are not imprisoned under federal, state, or local authority.
- I/we are 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.

[1+] 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)* | Social security number (SSN) | Date of birth *(mm/dd/yyyy)*

Relationship to you: ☐ Spouse ☐ Child ☐ Other

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)* | Social security number (SSN) | Date of birth *(mm/dd/yyyy)*

Relationship to you: ☐ Spouse ☐ Child ☐ Other

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)* | Social security number (SSN) | Date of birth *(mm/dd/yyyy)*

Relationship to you: ☐ Spouse ☐ Child ☐ Other

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.

Name & SSN ________________________

Part 4: Health Plan Information

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	Health plan name Blue Cross Blue Shield of Michigan	Effective date of coverage	Health plan ID number **Plan Administrator Provides**
	Provide at least one of the following ID Numbers.		
	Member ID	Group ID **Plan Administrator Provides**	Policy or plan ID
	Policy holder's name *(First, Middle Initial, Last, Suffix)*	Policy holder's SSN	Total monthly premium $
	1. Total number of people *(you and any family members)* on this policy		**1+**
	2. Number of family members on this policy who are not qualified for the HCTC		**N/A**
	3. Monthly premium amount for family members who are not qualified for the HCTC		**N/A**
	4. Other health benefits amount		**N/A**
	5. Total HCTC *Total monthly premium minus line (3) and multiplied by 27.5% (.275)*		**$0.00**
	6. Monthly HCTC payment *Line 4 plus Line 5*		**$0.00**
Complete this section only if you have COBRA coverage:	Former employer	Former employer's HR telephone 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.		

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. Complete the rest of this page and choose a PIN.

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

This section is optional, you can complete it, if you choose

Name of Third-Party-Designee *(First, Middle Initial, Last, Suffix)*	
Primary telephone number	Alternate telephone 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)

HCTC Registration form, BCBSM Enrollment Form & Supporting Documents will be mailed, emailed, or faxed to Benistar, NOT the HCTC

SSN ________________________

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.

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.

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Instructions for Form 13441-A Department of the Treasury

Retiree Name & SSN ____________________

Enrollee Name & SSN

Internal Revenue Service

(Rev. January 2016)

Health Coverage Tax Credit (HCTC) Monthly Registration and Update

Qualified Family Member Sample for January 2017

You Must Complete **ALL** Required Areas of this Form to Enroll in HCTC Monthly Insurance Program

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.

   Examples: Copy of IRS 1099-R, Paycheck Stub from PBGC Other document showing PBGC Check

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:

   Internal Revenue Service
   Stop 6[illegible] USC
   Austin, Texas 78741

   Do Not Mail to IRS!
   Fax:1-860-408-7025 or
   Mail: Benistar Service Center
   10 Tower Lane Suite 100 Avon, CT 06001

☒ 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.

☐ 6. Check here if you are updating your current mo[illegible]istration. When you are enrolled in the monthly HCTC Program, you must inform us of all changes tha[illegible]t your eligibility, your family members and your health insurance. You only need to provide the updat[illegible]mation.

7. Please note that once you mail the registration form it can take up to 6 weeks *(if all requirements are met)* before you receive registration confirmation. During this tim[illegible] must continue to pay your health insurance bills directly to your health plan and keep records of your paym[illegible]ou 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 Document

These instructions have been covered at top of page

The following document is required to be submitted with your HCTC Monthly Registration Form. Review the required document checklist carefully[illegible]ution: An incomplete form or missi[illegible]ocuments will delay the processing of your registration.

☐ **A copy of your heal[illegible]d withi[illegible]hat includes all of the following:**

- Your name • Healt[illegible]e number
- Monthly premium amoun[illegible]ation numbers • Dates of coverage • Address for mailing your payments

If applicable, y[illegible]

- Dollar amount[illegible]bers who are no[illegible]e HCTC
- Separate dollar[illegible]or benefits that the HCTC [illegible] 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.

Retiree Name SSN ______________________
Enrollee Name______________________

Form **13441-A**

(January 2016)

Department of the Treasury - Internal Revenue Service

Health Coverage Tax Credit (HCTC) Monthly Registration

OMB Number 1545-1842

Part 1: Your General Information

HCTC/TAA Eligible Recipient to Complete

Name *(First, Middle Initial, Last, Suffix)*

Social security number (SSN)	Date of birth *(mm/dd/yyyy)*	Primary telephone number	Alternate telephone number

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

Part 2: Confirm Your Eligibility

Retiree or TAA Recipient Completes Box 1 or 2, Qualified Family Members (QFM) Completes Box 3

Check the box that applies to you to certify that the statement is true:

(1) ☒ I am a PBGC payee and 55 years old or older.

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

Check the box to certify that you meet all general requirements listed below. Qualified Family Member(s) Completes Box 3

☒ (3) I certify that all of the following statements are true for me and my qualified family members.

- I/we are not enrolled in Marketplace insurance. Marketplace is Affordable Care Act (ACA)
- I/we are covered by a qualified health plan for which I pay more than 50% of the premiums.
- I/we are not enrolled in Medicare Part A, B, or C.
- I/we are not enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
- I/we are not enrolled in the Federal Employees Health Benefits Program (FEHBP).
- I/we are not enrolled in the U.S. military health system (TRICARE).
- I/we are not imprisoned under federal, state, or local authority.
- I/we are not claimed as a dependent on someone else's federal income tax return.

Part 3: Family Member Information

Qualified Family Member(s) (QFM) Completes the box(es)

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)*.

	Family member's name *(First, Middle Initial, Last, Suffix)*		Social security number (SSN)	Date of birth *(mm/dd/yyyy)*
1	QFM(s) Complete these Boxes			
	Relationship to you ☐ Spouse ☐ Child ☐ Other	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)*		Social security number (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you ☐ Spouse ☐ Child ☐ Other	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)*		Social security number (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you ☐ Spouse ☐ Child ☐ Other	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.

Name & SSN ____________________

Part 4: Health Plan Information

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	Health plan name Blue Cross Blue Shield of Michigan	Effective date of coverage	Health plan ID number **Plan Administrator Provides**
	Provide at least one of the following ID Numbers.		
	Member ID	Group ID **Plan Administrator Provides**	Policy or plan ID
	Policy holder's name *(First, Middle Initial, Last, Suffix)*	Policy holder's SSN	Total monthly premium $
	1. Total number of people *(you and any family members)* on this policy		1+
	2. Number of family members on this policy who are not qualified for the HCTC		N/A
	3. Monthly premium amount for family members who are not qualified for the HCTC		N/A
	4. Other health benefits amount		N/A
	5. Total HCTC *Total monthly premium minus line (3) and multiplied by 27.5% (.275)*		$0.00
	6. Monthly HCTC payment *Line 4 plus Line 5*		$0.00
Complete this section only if you have COBRA coverage:	Former employer	Former employer's HR telephone 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.		

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. Complete the rest of this page and choose a PIN.

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

This section is optional, you can complete it, if you choose

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

Primary telephone number	Alternate telephone 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)

HCTC Registration form, BCBSM Enrollment Form & Supporting Documents will be mailed, emailed, or faxed to Benistar, NOT the HCTC

SSN ________________________

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.

Signature	Full name *(print)*	Date

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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.

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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.

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