



# Retiree Only

**Instructions:** Please fill out all boxes highlighted in “Yellow”. The boxes highlighted In “Orange” will contain information that has been pre-filled on your behalf. Please complete all sections except Part 5.

Form <b>13441-EZ</b> (April 2010)	Department of the Treasury–Internal Revenue Service <b>Monthly Health Coverage Tax Credit (HCTC) Group Registration</b>	<b>OMB Number</b> 1545-1842
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**Part 1: Provide information about yourself**

Name ( <i>first, middle initial, last, suffix</i> )	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number (SSN)	Date of Birth ( <i>mm/dd/yyyy</i> )
Primary Telephone Number ( <i>include area code</i> )	Former Employer Delta Air Lines

**Part 2: Confirm Eligibility**

Check the box below to confirm your eligibility for the HCTC.  
 I certify that I meet all eligibility requirements for the HCTC as outlined in Part 2 of the Instructions.

**Part 3: Provide information about family member(s)**

Check the box below to confirm the eligibility of your family member(s) for the HCTC.  
 I certify that each family member listed meets all eligibility requirements for the HCTC as outlined in Part 3 of the Instructions.

Make a copy of this page before filling it out if you have more family members than the space allows and indicate the number of family members here. **Number of family members** 0

Family member's name ( <i>first, middle initial, last, suffix</i> )	Relationship to you <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Social security number (SSN)	Date of birth ( <i>mm/dd/yyyy</i> )

Is this person on your health plan?  
 Yes  No He or she has a separate plan (use Part 4 to provide this health insurance information, as applicable).

Is this person your third-party designee? (See Part 3 of the Instructions) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, create a five-digit Personal Identification Number (PIN)
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**Part 3 Instructions:** For the “Number of family members” please enter “0”. This number represents family members covered other than yourself.

Your third-party designee is someone you have the choice to appoint to handle your account to act on your behalf as a proxy. If you are appointing a third-party designee please enter their name next to the “Yes” or “No” box in the appropriate area within Part 3.



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## Part 4: Provide information about your qualified health insurance

If your family member is not on your health plan, make a copy of this page to provide his/her qualified health insurance information.

Please complete this section.	Name of health plan DP3 VEBA Trust		Type of coverage: <input checked="" type="checkbox"/> COBRA or VEBA <input type="checkbox"/> State-qualified	
	Health Plan ID number N/A	Member ID N/A	Group ID 476763	Policy or Plan ID
	Policy holder's name (first, middle initial, last, suffix)			Start date for coverage (mm/dd/yy)
	Policy holder's social security number			Total monthly premium
	Total number of people (you and any family members) on this policy			1
	Number of family members on this policy who are not eligible for the HCTC			0
	Monthly premium amount for family members who are not eligible for the HCTC			0.00
	Monthly premium amount that covers separate dental or vision plans			0.00
Complete this section only if you have COBRA coverage.	Your former employer N/A		Former employer's telephone number (include area code) N/A	
	End date for COBRA coverage (mm/dd/yy)		<input type="checkbox"/> Check here if this is a Lifetime Benefit	

## Part 5: Gather supporting documents

Please see Part 5 of the Instructions for information on supporting documents.

## 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 also agree to allow the IRS to share my eligibility status and payment information with my health plan.*

Signature	Full Name (print)	Date
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Catalog Number 54947M

Form 13441-EZ (4-2010)

**Part 4 Instructions:** For the “Total Monthly Premium” within Part 4 please enter the premium amounts associated with “Retiree Only” coverage.

Premium Plan:            \$951.46

Standard Plan:            \$698.79

**Part 5 Instructions:** Please leave this blank. Marsh will complete this section of the form.