

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

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** _____

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) If yes, create a five-digit Personal Identification Number (PIN)
 Yes No

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	Type of coverage: <input type="checkbox"/> COBRA or VEBA <input type="checkbox"/> State-qualified		
	Health Plan ID number	Member ID	Group ID	Policy or Plan ID
	Policy holder's name (<i>first, middle initial, last, suffix</i>)			Start date for coverage (<i>mm/dd/yy</i>)
	Policy holder's social security number			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 eligible for the HCTC			
	Monthly premium amount for family members who are not eligible for the HCTC			
	Monthly premium amount that covers separate dental or vision plans			
Complete this section only if you have COBRA coverage.	Your former employer		Former employer's telephone number (<i>include area code</i>)	
	End date for COBRA coverage (<i>mm/dd/yy</i>)		<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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