



Retiree + Child

Instructions: Please fill out all boxes highlighted in "Yellow". Please complete all sections.

Form **13704**
(Rev. September 2010)

Department of the Treasury—Internal Revenue Service
MONTHLY HCTC REGISTRATION UPDATE

OMB Number
1545-1954

Use this form to make updates to your monthly Health Coverage Tax Credit (HCTC) account. When you or your family members are enrolled in the monthly HCTC Program, you must inform us of all changes that affect your eligibility, your family members, and your health insurance. If you do not keep your HCTC account information current, you could risk losing the monthly HCTC.

Instructions:

1. **Keep a blank copy** of this form in your personal records for future use. This form can also be found at www.irs.gov/hctc.
2. Only use this form if you need to make **changes** to your HCTC account.
3. **Print or type** your responses. Leave blank any box that does not apply to you or your family members.
4. You must complete Part 5.
5. You must sign and date this form to confirm your continued eligibility for the HCTC.
6. Keep a copy of this completed Registration Update Form—and all required supporting documents—for your personal records.
7. **DO NOT SEND PAYMENT WITH THIS FORM.** Mail the completed form and required supporting documents to:
HCTC Processing Center
P.O. Box 760189
San Antonio, TX 78245

If you have any questions about this form, please contact 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).

Part 1: Provide information about you

Your name (<i>first, middle initial, last, suffix</i>)	Your gender (<i>male, female</i>)
Your mailing address (<i>street address</i>)	(<i>city, state, zip</i>)
Social security number	Date of birth (<i>mm/dd/yyyy</i>)
Primary telephone number (<i>include area code</i>)	Check here if address or phone has changed <input type="checkbox"/>

Note: You must also provide mailing address changes to the agency that reports you as eligible for the HCTC Program. This is either your state (unemployment office) or the Pension Benefit Guaranty Corporation (PBGC).

Part 2: Confirm your eligibility

Check the boxes that apply and certify that the following statements are true.

You or your family member(s) are:

- An eligible Trade Adjustment Assistance (TAA), Alternative TAA (ATAA), or Reemployment TAA (RTAA) recipient; a Pension Benefit Guaranty Corporation (PBGC) payee; or a qualified family member eligible for the HCTC due to the death of or divorce from a PBGC payee or TAA recipient.
- Covered by a qualified health plan for which you paid the premiums, or your portion of the premiums, directly to your health plan.
- Paying more than 50% of your health insurance premium. (An employer does not pay 50% or more of your premium.)
- Not enrolled in Medicare Part A, B, or C or you are, but are only claiming premiums for qualified family members.
- Not enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
- Not enrolled in the Federal Employees Health Benefits Program (FEHBP) or the U.S. military health system (TRICARE).
- Not imprisoned under federal, state, or local authority.
- Not receiving a 65% COBRA Premium Reduction.

If you do not certify all of the statements above, you are no longer eligible to receive the HCTC and should not submit this form. Instead, call the HCTC Customer Contact Center to tell us about this change.

Part 2 Instructions: Please make sure to check all boxes that apply to confirm eligibility.



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Part 3: Tell us what to change on your HCTC account

Check all that apply.	Effective date of change (mm/dd/yyyy)
<input type="checkbox"/> Add or remove a family member.	
<input type="checkbox"/> Change information about my or my family member's current health insurance (e.g., change in premium amount, change in any ID numbers, change in address where payments are currently sent).	
<input type="checkbox"/> The administrator for my COBRA coverage has changed (COBRA only).	
<input checked="" type="checkbox"/> I or my family member(s) have <i>new</i> HCTC qualified health insurance.	
<input type="checkbox"/> Switch my eligibility type from TAA (or ATAA/RTAA) to PBGC. To switch your eligibility type from TAA to RTAA, call the HCTC Customer Contact Center.	
<input type="checkbox"/> Check this box to reactivate your HCTC account if you were enrolled within the last 90 days.	

Part 3 (Continued)

Reason for update

Part 4: Provide information about a family member	Add eligible family member <input type="checkbox"/>
	Remove ineligible family member <input type="checkbox"/>

Make a copy of this page before filling it out if you have more family members than the space allows.

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	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 5 to give this health insurance information, as applicable).

Part 3 Instructions: Please check off the boxes indicating changes to your HCTC account. Box 4 should be the most common occurrence but please check any others that are applicable to you.

Part 4 Instructions: Please complete this section for each family member. You will need to make copies of this page for additional family members in order to capture their personal information.



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Part 5: Provide information about your qualified health insurance

Part 5 is required. You must submit proof of insurance (e.g., a current bill) and any other required documentation for the health insurance policy you describe below. See the "Supporting Documents Checklist" in the HCTC Program Kit or visit www.irs.gov/hctc for detailed information on the supporting documents you must submit.

Please complete this section.	Name of health plan DP3 Veba Trust	Type of coverage:	<input type="checkbox"/> COBRA	<input type="checkbox"/> State-qualified
	Health plan ID number N/A	Member ID N/A	Group ID 476763	Policy or plan ID
	Policyholder's name (first, middle initial, last, suffix)			
	Policyholder'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			2
	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	Former employer's telephone number (include area code)
	Start date for COBRA coverage (mm/dd/yy)	End date for COBRA coverage (mm/dd/yy) <input type="checkbox"/> 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 telephone number (include area code)
	Your last paid day of work for that employer	Start date of non-group/individual insurance

*If you have this type of health plan, additional supporting documents are required. Visit www.irs.gov/hctc. Click the link for "The Monthly HCTC."

Part 6: Sign and date this form to confirm your HCTC eligibility

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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PAPERWORK REDUCTION ACT NOTICE. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Your response is voluntary. You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless 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 become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by code section 6103. The estimated average time to complete this form is 15 minutes. If you have comments concerning the accuracy of this time estimate or suggestions for making this form simpler, we will be happy to hear from you. You can write to the Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, Washington, DC 20224.

PRIVACY ACT STATEMENT. The following information is provided to comply with the Privacy Act of 1974 (P.L.93-579). All information collected on this form is required under the provisions of 31 U.S.C. 522 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data, by electronic means to vendor's financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the Automated Clearing House Payment System.

Part 5 Instructions: For the "Total Monthly Premium" within Part 5 please enter the premium amounts associated with "Retiree + Child" coverage.

Premium Plan: \$1,560.59

Standard Plan: \$1,156.34

Part 6 Instructions: Please remember to sign and date the form.