RETIREE ONLY SAMPLE

PAGE 1

Instructions for Form 13441-A
(May 2017)
Health Coverage Tax Credit (HCTC)
Monthly Registration and Update

Department of the Treasury
Internal Revenue Service

BESTCO BENEFITS LLC/BENISTAR

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

   Internal Revenue Service
   Stop 6098 AUSC
   Austin, Texas 78741

☐ 5. Check here if you are registering as a Qualified Fa[illegible]Member. Note: Qualified Family members of HCTC eligible individuals may receive the HCTC for up to 24 mon[illegible] following the eligible individual's Medicare enrollment, death or divorce. For more information on Qualified Fa[illegible]ember eligibility, see Form 8885 instructions under Qualified Family Member.

☐ 6. Check here if you are updating your current monthl[illegible]gistration. When you are enrolled in the monthly HCTC Program, you must inform us of all changes that aff[illegible] your eligibility, your family members and your health insurance cost. You only need to provide the upd[illegible]ed [illegible]formation.

Note: Please note that once you mail the HCTC Monthly Registration and Update form, it can take up to 6 weeks *(if all requirements are met)* before you receive regist[illegible]n confirmation. During this time, you must continue to pay 100% of your health insurance bills directly to your [illegible]lth plan and keep records of your payments. You can claim the yearly tax credit for these and any months tha[illegible]you[illegible]met all eligibility requirements and made payments directly to a qualified health plan on your federal income [illegible]ax return.

Required Supporting Document and Information

The following document is required to be submitted with your HCTC Monthly Registration and Update form. Review the required document checklist carefully. Caution: An incomplete form or missing documents will delay the processing of your registration.

☐ **A copy of your health insurance bill dated withi[illegible] the last 60 [illegible]hat includes all of the following:**

- Your name
- Monthly premium amount
- Dates of coverage
- Health[illegible]me [illegible]e number
- Health [illegible] numbers
- Address [illegible]r payments

If applicable, your bill must show the follow[illegible]

- Dollar amount for family members who [illegible] for the HCTC
- Separate dollar amount for benefits t[illegible] not cover *(such as separate dental or vision plans)*

Usually, your health insurance bill will have al[illegible]mation [illegible] it does not, you will need a letter or another document from your Health Plan that include[illegible]ormation.

You should confirm with your Health Plan P[illegible] or Third Party Administrator if applicable that they meet the IRS payment requirements through the Direct Deposit Program, including filing Form 3881, ACH Vendor/Miscellaneous

Instructions:

1.) Please make sure to write in BESTCO BENEFITS LLC/ BENISTAR, the Retiree (PGBC Recipient) Social Security Number on the top of EACH PAGE in the Your SSN space.

2.) Examples of supporting documents are:

⇒ copy of the IRS 1099-R form

⇒ Paycheck stub from PBGC

⇒ Other document showing PBGC check (ie, bank statement)

RETIREE ONLY SAMPLE

PAGE 2

John Doe

Your SSN ____________

Form **13441-A** (May 2017)	Department of the Treasury - Internal Revenue Service **Health Coverage Tax Credit (HCTC) Monthly Registration and Update**	OMB Number 1545-1842

Part 1: Your General Information

HCTC Eligible Recipient name *(First, Middle Initial, Last, Suffix)*
John A. Doe

Social Security Number (SSN)	Date of birth *(mm/dd/yyyy)*	Primary telephone number	Alternate telephone number
505-41-3232	05/04/1955	555-432-9876	

Mailing Address *(Street Number, City, State, ZIP)*
222 Mayberry Circle, Detroit, Michigan 73347

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.

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

☑ I certify that all of the following statements are true for me and my qualified family members.

- I/we are not enrolled in an Affordable Care Act Marketplace insurance.
- 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, C, or D.
- 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 ea… …ily membe… …elow:

- My family member is my spouse or claimed as a dep… …n my f… …ome tax return and
- My family member meets all general requirements for … …art 2 *(with the exception of the last bullet)*.

1	Family member's name *(First, Middle Initial, Last, Suffix)*	…al security number (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you ☐ Spouse ☐ Child ☐ Other	Is this person c… …n? ☐ Yes ☐ … Pa… a separate qualified plan. Make a copy of the next page …vide their health insurance information.	
2	Family member's name *(First, Middle Initial, Last,*	…ecurity number (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you ☐ Spouse ☐ Child ☐ Other	Is this … 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)*

Instructions:

1.) Please make sure to write in the Retiree (PGBC Recipient) Name and Social Security Number on the top of EACH PAGE in the Your SSN space. We realize there is no place for the name… just write above the SSN

2.) COMPLETE ALL SHADED AREAS

3.) Part 3 is not required for Retiree Only Form

RETIREE ONLY SAMPLE

PAGE 3

John Doe

Your 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 Provider name	Effective date of coverage	Health plan ID number
	08/01/2017	

HCTC vendor name *(name of company to be payed on your behalf)*
BESTCO BENEFITS LLC/BENISTAR

HCTC vendor number *(contact your Health Plan Provider or Third Party Administrator)*
01958486

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
John A. Doe	505-41-3232	$1,872.99

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	
3. Monthly premium amount for family members who are not qualified for the HCTC	
4. Other health benefits amount	
5. Total HCTC *Total monthly premium minus line (3) and multiplied by 27.5% (.275)*	$515.07
6. Monthly HCTC payment *Line 4 plus Line 5*	$515.07

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 and Update form.

Name of Third-Party-Designee *(First, Middle Initial, Last, Suffix)*
Jane C. Doe

Primary telephone number	Alternate telephone number
555-432-8822	

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)

	4	2	2	2

Instructions:

1.) Please make sure to write in the Retiree (PGBC Recipient) Social Security Number on the top of EACH PAGE in the Your SSN space.

2.) COMPLETE ALL SHADED AREAS

(green shaded area is optional)

3.) Health Plan ID Options: SAMPLE WILL REPRESENT COMMUNITY BLUE PPO (HCTC1) PLAN OPTION

(for sample purposes only)

PLEASE SEE RATES AND PLAN OPTIONS TO HELP SELECT THE APPROPRIATE PLAN AND CHECK RATES AND CREDITS.

RETIREE ONLY SAMPLE

PAGE 4

John Doe

Your 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
	John Doe	06/11/2017

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.

Instructions:

1.) Please make sure to write in the Retiree (PGBC Recipient) Social Security Number on the top of EACH PAGE in the Your SSN space.

2.) sign, print full name and date the form