Form **14095** (January 2017)	Department of the Treasury - Internal Revenue Service **The Health Coverage Tax Credit (HCTC) Reimbursement Request Form**	OMB Number 1545-2152

Use this form to request an HCTC reimbursement credit for premiums you paid directly to a qualified health plan while you were eligible and enrolling in the monthly HCTC Program. You must be a Monthly HCTC Participant or have an HCTC registration in process for your request to be considered.

Instructions

1. Print or type your responses. Complete all parts of this form.
2. Provide verifiable proof that your health plan is qualified for the Health Coverage Tax Credit and that you paid the qualified health insurance premiums by attaching the required supporting documents to your Reimbursement Request Form.
3. Mail the completed form and required supporting documents to: Internal Revenue Service
   Stop 6098 AUSC
   Austin, TX 78741

NOTE: That once you mail the HCTC Reimbursement Request Form, it can take up to 12 weeks (if all requirements are met) before you receive your reimbursement.

4. **NEXT:** If your request is not approved, the HCTC Program will send a letter that explains why your request was denied.

Part 1: Provide Information About You

Your name *(first, middle initial, last, suffix)*	Social security number *(last four digits)*		
Your mailing address *(street address)*	City	State	ZIP code
Telephone number	HCTC participant identification number *(from Letter 4545)*		

Part 2: Determine Eligibility and Request Reimbursement

Complete this section to request reimbursement. You can request reimbursement for premiums you paid for qualified coverage while you were eligible and enrolling in the monthly HCTC Program. You can request reimbursement beginning with the ***month of the date*** of your enrollment letter. For each month you are requesting reimbursement, you need to confirm that you 1) met all eligibility requirements for the HCTC and 2) made payments directly to a qualified health plan.

Check the box next to each month of this calendar year for which you are requesting reimbursement and for which each of the following statements were true on the first day of that month.

- You were an eligible Trade Adjustment Assistance (TAA), Alternative TAA (ATAA), or Reemployment TAA (RTAA) recipient, or a Pension Benefit Guaranty Corporation (PBGC) payee age 55 years or older.
- You were covered by HCTC-qualified health insurance coverage for which you paid the premiums, or your portion of the premiums, directly to your health plan to match Form 8885 and a style change requested by Treasury.
- You were ***not*** enrolled in Medicare Part A, B, or C.
- You were ***not*** enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
- You were ***not*** enrolled in the Federal Employees Health Benefits Program (FEHBP) or eligible to receive benefits under the U.S. military health system (TRICARE).
- You were ***not*** imprisoned under federal, state, or local authority.
- Your or your spouse's employer (or former employer) ***did not*** pay 50% or more of the cost of coverage.
- You cannot be claimed as a dependent on someone else's federal income tax return.

☐ January	☐ February	☐ March	☐ April	☐ May	☐ June
☐ July	☐ August	☐ September	☐ October	☐ November	☐ December

Enter the **TOTALS** for **ALL MONTHS** checked above

1.	Enter the **total** amount you paid directly to your qualified health plan	
2.	Enter the total amount you paid for dental or vision benefits. These benefits do not qualify for the HCTC	
3.	**Subtract line 2 from line 1. Enter the total**	
4.	Enter total amount you paid for family members that are not qualified for the HCTC	
5.	**Subtract line 4 from line 3. Enter the total**	
6.	**Multiply line 5 by 72.5% (0.725). Enter the total. This is your Total Requested Reimbursement**	

Part 3: Gather Supporting Documents

You must provide copies of the corresponding health insurance bills or payment coupons for the months identified in Part 2 of this form. These documents must show the following information:

- Your name (or name of the policy holder)
- Social Security number of Policy Holder if different from requester
- The name of your health plan
- Your monthly premium amount
- Dates of coverage
- Your health plan identification number(s) including member ID, Group ID, Policy or Plan ID

Note: If your qualified health plan does not provide members with an insurance bill or COBRA payment coupon, you must provide health plan enrollment documents or an official letter from your health plan that has the required information listed in the bullets above.

You must also provide proof that you paid those premiums. Acceptable proof of payment includes:

- Canceled checks (copy of front and back)
- Bank statements
- Credit card statements
- Money Order receipts

Note: Your proof of payment must indicate the amount paid and to whom it was paid. If you do not have one of these types of proof of payment, contact your health plan for a record of your payment(s).

Part 4: 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 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 or type)*	Date

If you have any questions about this form, please contact the Internal Revenue Service toll-free at 1-844-853-7210.

Paperwork Reduction Act Notice And Privacy Act Statement

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. 3322 and 31 CFR 210. We use the information you submit to determine if you qualify for reimbursement of 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.